

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

COUNTERPART
C&D WITH HEALTH CARE EDITOR PHILIP HASTING

16 MARCH 1996

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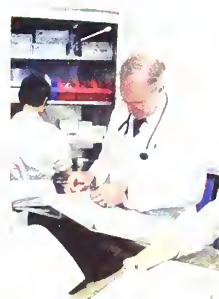
BUSINESS IS LOOKING GOOD

Malone sets up script fraud squad

RPSGB makes moves on managed care

Counterpart: the route to accreditation

Update: in search of the dream team



Salary survey shows little incentives in-store

Ciba and Sandoz make Novartis in £50bn deal

Unilever refocus moves along with Rimmel sale

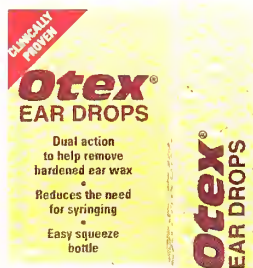
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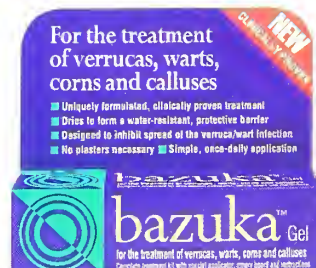
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The referral of the two competing bids for Lloyds Chemists to the Monopolies and Mergers Commission was a major topic of conversation at the BAPW dinner last Monday. Neither protagonist is happy about the referral, nor do they know yet on what grounds it has been made. Since Boots the Chemists will still be the UK's largest pharmacy multiple, it is unlikely to be concern over fears of a retail monopoly. Unichem believed it had squared away problems on the wholesale side before making its bid. BAPW chairman David Linney points the finger at the Department of Health, suggesting it is keen to maintain the current wholesaler status quo.

The DoH cannot, of course, directly interfere, but there is little to stop senior officials expressing concern behind the scenes. The Department's concern presumably stems from the fact that it faces a duopoly where both parties might like to stretch their margins by widening the gap between the 12.5 per cent they get from manufacturers and the 7 or so per cent passed on to their pharmacy customers. Reducing customer discounts would knock a hole into the £230 million a year the Department currently claws back from pharmacists, which would not sit well with HM Treasury.

This is all speculation, but it has a corollary. Ministers, who before Christmas might have been ignorant of the importance of RPM on medicines to both retail pharmacies and pharmaceutical wholesalers, have been publicly warned of the consequences on a number of occasions recently. If the DoH is concerned over the bids for Lloyds Chemists, it should be more worried about the threat to RPM. One is left wondering whether the Department will offer its views privately on this issue.

CHEMIST & DRUGGIST

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CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR THE PHARMACY

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Malone sets up script fraud squad

A Prescription Fraud Squad is to be created to crack down on patients, GPs and pharmacists who are thought to be cheating the NHS of \$30 million a year.

Health minister Gerald Malone announced this week he would be setting up a 40-strong team of investigators and legal experts to help eliminate malpractice.

The prescription fraud unit, based at the Prescription Pricing Authority's Newcastle headquarters, will investigate fraud committed by patients and malpractice by professional staff.

Mr Malone said the new FP10s, which require patients to declare the charge paid and the reason for exemption, had made inroads into the problem.

The unit will cost £800,000 to set up – "a fraction of the cost of the fraud it is to investigate", said the health minister.

While both the Royal Pharmaceutical Society and the National Pharmaceutical Association welcome the move, there is little information on how the new unit will operate – raising fears that prescription exemption 'polic-



ing' by pharmacists will be ushered in.

Both are opposed to such a development. "Any such role would be to the detriment of the pharmacist's relationship with patients," says the Society.

The NPA's assistant director,

John D'Arcy, says it will resist the move "all the way down the line. If pharmacists were being forced to be inspectors it would be a nonsense. The relationship between pharmacists and patients is founded upon trust".

However, the Pharmaceutical

Services Negotiating Committee's secretary, Stephen Axon, comments that he does not expect 'policing' to be introduced. "We have made it very clear that PSNC would not accept pharmacists being used to 'police' exemptions," he says.

Welsh pharmacist to be patient care director

A pharmacist has been appointed director of patient care in the newly-created Iechyd Morgannwg Health Authority.

Alan Willson, pharmacy adviser for West Glamorgan, will take up his post when the health authority merges with Bridgend HA on April 1. He believes he is the only pharmacist appointed to an executive position in the five new Welsh health authorities.

His responsibilities will include primary care development and nursing home inspection.

Scherer concedes defeat

Pharmaceutical company R P Scherer has conceded defeat over the Government's decision to ban temazepam capsules, despite a judgment last week that gave the company leave to appeal (*C&D* last week, p297).

The Government's temazepam blacklisting was upheld by a High Court judge in a ruling reserved from the previous week's judicial review hearing. Justice Judge decreed the ban was justified by the danger posed to thousands of addicts.

Scherer was ordered to pay the action's heavy legal costs.

Council election deadline

Would-be Royal Pharmaceutical Society Council election nominees have to move swiftly, as the nomination forms must reach Lambeth by Monday, March 18.

Seven Council members are up for re-election (David Allen,

Geoff Booth, Ian Caldwell, David Coleman, Ann Lewis, Alan Nathan and Hemant Patel), with voting papers to be sent out on April 15.

These must be returned to the Society by May 17.

More GPs approve OTC deregulation

More GPs favour wider availability of certain medicines over the counter, compared to five years ago.

GPs agreed that, in certain cases, pharmacists should be able to supply oral nystatin suspension, co-dydramol and chloramphenicol eye drops without prescription, says a report in the *British Medical Journal*.

The study, conducted in 1994, compared how GP attitudes had changed since a similar survey in 1990.

OTC co-dydramol (ten tablets) for severe toothache at the weekend was supported by 87 per cent

of respondents, and oral nystatin suspension for oral candidosis in babies by 80 per cent.

The biggest increases in support for OTC status were for the 'morning after pill' and a three-day course of trimethoprim for frequency and dysuria in women.

Dr James Kennedy, senior lecturer in general practice at Charing Cross and Westminster Medical School, supports the trend. In a *BMJ* editorial, he says: "The remuneration system for community pharmacists must be adapted to reward those who give accurate advice to patients and liaise with GPs."

PSNC tells Major to embarrass DoH

The Pharmaceutical Services Negotiating Committee is calling on the prime minister to embarrass the Department of Health into making prompt payment to pharmacists.

The chairman of PSNC, David Sharpe, has asked the prime minister to confirm that he "will be instructing the Department to improve the current payment timetable for NHS community pharmacy contractors".

The PSNC strategy has arisen in the light of John Major's pledge to tackle the problem of late payment of bills and his order to Government departments to pay promptly. Mr Major promised to publish league tables of the worst offenders.

Tim Astill, the director of the National Pharmaceutical Association, has also written to the PM, congratulating him on his "initiative to crack down on late payers".

Godfrey Horridge, financial director at the PSNC, is also writing to the public accounts committee at the House of Commons and the National Audit Office and briefing the Labour Party's small business spokeswoman, Barbara Roche.

Home group seeks pharmacists

Home care company Community Careline Services is looking for pharmacists to become franchisees and expand its facilities.

The company, set up in 1990, provides elderly and disabled people with a service in their own homes, equal to that provided by residential care. An alarm system offers 24-hour help. Over 200 franchisees service 40,000 UK clients.

For £20,000, plus VAT, pharmacists will be given an exclusive territory and business management package. A spokeswoman envisaged pharmacists including prescription collection and delivery as one of the possible services.

For further details contact: 0161 877 4477.

Society launches managed care document

Pharmacists have to ensure they are central to the concept of managed care – or watch as the profession becomes marginalised in medication management, warns a new report commissioned by the Royal Pharmaceutical Society.

'Managing medicines: managing care' by Deloitte and Touche Consulting Group, highlights the increasing drive towards managed care and illustrates the role pharmacists would play in this New Age.

Dr Sue Ambler, the Society's head of practice research, sees the report as a window on the profession, but adds: "A lot of it is laid at the pharmacist's door to meet health authorities and purchasers halfway."

The document concludes that:

"Managed care represents the greatest challenge facing pharmacy today ... Pharmacists could, through managed care, be effectively harnessed to address many of the key areas of concern to the NHS."

Pharmacists could focus on the added value they bring to patient management which would improve the cost-effectiveness of medicinal therapy. The foundations are already in place: formularies, prescribing protocols, generic prescribing and drug utilisation review harnessing PACT and SPA data.

The report strongly emphasises that the way the profession progresses lies firmly in its own hands. Pharmacy and its representative bodies should "seize the opportunity and ensure the

future of pharmacy at the heart of the healthcare system". Rather than being a reactive profession which waits for purchasers to act, "it should lead the debate on the reinvigoration of pharmacy and provide pharmacists with the necessary capital bases".

Failure to do so, it says, "may pose a real threat to pharmacy and the profession could become marginalised".

'Managing medicines: managing care' is being sent to health authority chairmen, chief executives, pharmaceutical advisers and health policy research groups, as well as the pharmacy organisations and schools of pharmacy. Pharmacists who wish for copies, at a cost of \$7.50, should contact: Anita Constable on 0171 735 9141.

Wholesale sector in equilibrium

The wholesale sector appears to have reached an equilibrium between national and regional players.

Recent events "would seem to indicate that the Department of Health is keen to maintain this status quo", according to David Linney, chairman of the British Association of Pharmaceutical Wholesalers.

Speaking at the BAPW's annual dinner on Monday, he implied that the DoH had a hand in referring the two competing bids for Lloyds Chemists to the Monopolies and Mergers Commission.

The principal threat currently facing wholesalers was the removal of Resale Price Maintenance on medicines, he said, although he believed the odds were now 60:40 in favour of retention.

The introduction of patient packs was also having an impact, even though at least 40 per cent of affected products were already in place before the official launch at the end of 1995.



BAPW chairman David Linney

Relationships between wholesalers and manufacturers had recovered from the all-time low at the time of the introduction of the Glaxo agency scheme, he said. "The interface has never been better, albeit at the operational level. But there still exists within certain companies the concept that wholesalers are a

necessary evil, which reduce manufacturers' profitability by 12.5 per cent, only to give away 7 per cent, on average, in discount.

"While the competition aspect was an issue, a degree of reality now exists and the actual competition band above and below the average discount level is very narrow indeed."

Mr Linney described the difference between the two figures as a settlement discount. "Remove that from the wholesaler equation by reducing the 12.5 per cent under any future PPRS and the destabilising effect would spread through all sectors," he warned.

A reduction in cash flow due to removal of the prompt payment incentive for pharmacists would mean a reduction in stockholding and service levels, and delays in payment to suppliers with resulting loss of settlement discount, predicted Mr Linney.

The wholesale sector was good value for its 12.5 per cent, he insisted.

London's big smoke

Pharmacists in Redbridge and Waltham Forest are to monitor their contribution to smoking cessation in a £10,000 project.

"We wanted to see if pharmacists' advice on smoking cessation has any impact on local smoking patterns," says the Family Health Services Authority's pharmaceutical adviser, Emma Russell.

Each of the 26 participating pharmacies will recruit ten patients and return an individual client profile to the FHSA after three months. The FHSA will follow up patients at three and six months via postal questionnaires.

Pharmacists will be paid \$5 per client for the initial interview with a further \$10 payment for each completed client profile.

● A smoking cessation project involving six Glasgow pharmacists has highlighted the need for effective targeting of patients.

Out of 75 clients counselled around No Smoking Day last year, only three had remained non-smokers at the end of the three-month and six-month follow-up periods.

Counterpart: baby boom

Babycare is the topic in question in this month's Cambridge Counterpart Pharmacy Assistant's Development Course.

The Pharmacist's Briefing in this week's issue (see p345) covers breast- and bottle-feeding, weaning, teething, colic, crying and nappy rash.

This course is now accredited by the College of Pharmacy Practice. See p334 for further details of how sign up.

Council brings rural pharmacy difficulties to Commons' attention

The plight of rural pharmacies has been addressed by the Royal Pharmaceutical Society in a submission to the Environment Select Committee.

The Committee is securing comments on a 1995 Department of Environment and Ministry of Agriculture, Fisheries and Food White Paper 'Rural England', which touched on the importance of community pharmacy to isolated populations.

The Society's Council points out that people living in rural areas should have access to a full pharmaceutical service, but that the NHS regulations governing rural pharmacy applications "does not encourage ... and positively militates against" these being granted.

The granting of rural pharmacy contracts are "virtually always delayed" because of opposition from doctors who do not wish to

lose their right to dispense.

Council also recommends a change in the regulations to prevent contracts being granted to doctors dispensing from premises within one kilometre of a pharmacy.

This would prevent the market town situation arising, where doctors dispense from within the town for patients living more than a mile from the nearest pharmacy.

Act now for accredited Counterpart assistant training

It's time for existing course users to prepare for certification; new users must register now for their progress to be officially monitored

Accreditation of the Cambridge Counterpart Pharmacy Assistant Development Programme last week means that pharmacists wishing to use it must register their medicines counter assistants with *Chemist & Druggist* now in order to qualify for a College of Pharmacy Practice certificate.

College requirements also stipulate that independent verification of marking is carried out by the course providers – with *C&D's* innovative telephone marking system offering the ideal solution. Hundreds of assistants have been using this service successfully since the programme began in July, 1995, and it is the option recommended by *C&D* to new course participants. **The key decision points for community pharmacists are:**

1 For assistants already follow-

ing Counterpart and registered for telephone marking

Continue with the course (including the progress module – see below). Once it is completed you will receive the results and documentation for CPP certification (see Section A right)

2 For assistants following Counterpart, but not registered for telephone marking

Use the form opposite to register now. When your assistants receive their PINs, they should enter their multiple choice questionnaire responses up to date, then follow the course to the end. CPP certification will be available as above (see Section B right)

3 For assistants not yet following Counterpart

Use the form opposite to register now. If you have retained the free modules sponsored by Whitehall Laboratories, start your assistants on the course at once and mark the questionnaires as soon as PINs are received. If you do not still have the free modules available, use the order form on the page opposite to obtain complete packs of modules issued to date, plus questionnaires and Pharmacist Briefings (see Section C below).

Fees

The Royal Pharmaceutical Society of Great Britain has levied a fee of \$5 per assistant certificated by the College of Pharmacy Practice.

This fee must be collected by the course provider and paid to the College when submitting verification that the candidate has completed the course and achieved the required standard. The College will then issue its own certificate to the assistant.

Progress module

An additional requirement set by the CPP is that candidates' should be monitored externally by the course provider. This is already accomplished by *C&D's* telephone marking, but as a beneficial revision aid an extra progress questionnaire (numbered 14, but published alongside module 11) is being added. It will cover modules 1-9. The number of questionnaires covered by telephone marking will therefore extend from 13 to 14.

Cambridge Counterpart Assistant Development Log

Pass marks are given in the header box for each module. Modules one to six list any questions which are subject to the pharmacist's judgment and where it may be difficult to answer simply 'true' or 'false', in these, the pass mark is adjusted accordingly from module seven on, only true or false answers are possible. Assistants are allowed two attempts to answer questions, whether marked by the pharmacist or the telephone marking system (PIN), with appropriate scoring by the pharmacist in each case, the highest score is logged, dated and initialled in 'pass' box by the pharmacist. For details of Progress MCQ, see over and March 16 *C&D*

	1 Summative Health Variable Pass: 10 Score: 10/10	2 Medicines and Pharmacy Variable Pass: 10 Score: 10/10	3 Pharmaceutical Law Variable Pass: 10 Score: 10/10	4 Pharmaceutical Practice Variable Pass: 10 Score: 10/10	5 Pharmaceutical Practice Variable Pass: 10 Score: 10/10	6 Pharmaceutical Practice Variable Pass: 10 Score: 10/10	7 Pharmaceutical Practice Variable Pass: 10 Score: 10/10	8 Pharmaceutical Practice Variable Pass: 10 Score: 10/10	9 Pharmaceutical Practice Variable Pass: 10 Score: 10/10	10 Pharmaceutical Practice Variable Pass: 10 Score: 10/10	11 Pharmaceutical Practice Variable Pass: 10 Score: 10/10	12 Pharmaceutical Practice Variable Pass: 10 Score: 10/10	13 Pharmaceutical Practice Variable Pass: 10 Score: 10/10	14 Pharmaceutical Practice Variable Pass: 10 Score: 10/10
Name	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score
PIN no	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Date recorded	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Name	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score
PIN no	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Date recorded	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Name	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score
PIN no	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Date recorded	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /

Pharmacy name: _____ Address: _____
 Telephone: _____ Fax: _____
 Each pharmacist involved with Counterpart must sign this document
 Signature: _____ Initials: _____
 Signature: _____ Initials: _____
 Registration number: _____
 Registration number: _____

With this issue – your in-pharmacy training record

Cambridge Counterpart Pharmacy Assistant Development Programme is *Chemist & Druggist's* cost-effective solution to the Royal Pharmaceutical Society's requirement that by July 1, 1996, medicines counter assistants must be undertaking, or have already completed, an approved course of training.

Experienced assistants also have the option to take a multiple choice question paper (MCQ) set by the Society – ideally after using Counterpart as part of their revision process. The next two opportunities for examination are on May 23 and November 14 (see *C&D* March 9, p297 for details).

Thanks to the generous sponsorship of Whitehall Laboratories, all *C&D's* community pharmacy subscribers have received free monthly topic-based training modules since July last year. Each unit in the 13-module distance learning programme is for use by up to four assistants and comes complete with four individual question papers, plus a case study for discussion with the supervising pharmacist.

In the week preceding each module, a 'Pharmacist's Briefing' in *C&D* provides professional guidance on serious disease and other implications arising from the training process – picking up particularly from the point where assistants are instructed to 'Refer to the pharmacist'.

Assistants' progress is monitored in the pharmacy using the 'Development Log' (copies are included with this issue of *C&D*), but independent monitoring and marking by the course provider are required for achievement to be recognised for certification by the College of Pharmacy Practice.

An unhappy saga ...

With accreditation of the first batch of courses, can the dust at last begin to settle on the sorry saga of medicines counter assistant training?

After a trail of damaging *Which?* and media exposes on the shortcomings of pharmacy advice, it was inevitable that the Royal Pharmaceutical Society should take action to compel weak links in the profession to come into line. But was ever a good idea put into practice so ineptly?

Council started the process as long ago as February, 1994, issuing a consultation document covering both the training of assistants and protocols for the sale of medicines. At first, things went well, and by July that year the requirements had been added to the Code of Ethics.

On training, Council made clear the standards it expected

by comparison with existing courses. Logically, any new course which bettered those standards would therefore meet the designated requirements for accreditation.

So with a deadline of July, 1996, having been set – and the profession's urgent need to get on with the job – it is hardly surprising that course providers began work to give community pharmacists the training tools they needed.

The National Pharmaceutical Association's Interact, closely followed by *C&D's* Counterpart, were launched in the spring and summer of 1995 with encouragement to pharmacists to enroll staff so that *Which?* might soon be reporting about pharmacy in the positive. It was implicit that these courses would eventually receive accreditation.

But who was to give accredita-

How to get assistant certification through Counterpart

AFor assistants registered for telephone marking (PIN users)

If your assistants are subscribing to *Chemist & Druggist's* interactive telephone marking system they will automatically be registered with C&D as a course provider. Your assistant(s) will shortly receive their learning record for the first seven modules.

You should complete and retain the Assistant Development Log delivered with this issue (March 16) as your in-pharmacy training record.

Each PIN user will need to complete, as soon as possible, 'Progress MCQ' 14, to be delivered with C&D on April 27, along with Module 11.

When your assistant successfully completes the Counterpart course, we will send you a completion certificate, and a letter to sign and return to C&D magazine. The letter requires you to acknowledge that you have monitored, and that your assistant has attained, satisfactory communication skills, and that together you have worked through each set of case studies.

Charges

There will be a charge of £2.50 (plus \$0.44 VAT) to cover processing of an assistant's certification through the College of Pharmacy Practice.

There will be an additional £5 (plus \$0.88 VAT) charge levied by the Royal Pharmaceutical Society for each assistant certificated by the CPP.

These monies will be requested on course completion.

BFor assistants following Counterpart, but not yet registered (non-PIN users)

If your assistants have been using Counterpart and retaining the elements of each Pharmacy Assistant Development Module as it has been completed, you will need to register with *Chemist & Druggist* as a course user. The College of

Pharmacy Practice requires C&D to verify your assistant's learning achievement.

We suggest our interactive telephone marking system (PIN) will allow your assistants to do this most easily.

Please complete and retain the Assistant Development Log delivered with this issue as your in-pharmacy training record.

Each new PIN user will need to complete as soon as possible 'Progress MCQ' 14, to be delivered with C&D on April 27, along with Module 11.

On payment of the requisite fee, C&D will issue your assistants with a PIN and they will automatically become registered as course users. They should then log their MCQ results attained to date.

Charges

Registration fee (to cover issue of PIN for telephone marking) \$12.50.

Administration charge for CPP certification £2.50, and RPSGB levy \$5.

TOTAL £20 (plus \$3.50 VAT).

Manual users

If your assistants do not have access to a touch tone telephone, or you wish to continue with the manual marking system, please write to John Skelton, associate publisher, Pharmacy Group Special Projects at *Chemist & Druggist*, Miller Freeman Professional, Miller Freeman House,

Sovereign Way, Tonbridge, Kent TN9 1RW. Special arrangements will be made to cope with your requirements.

Charges

The all-inclusive fee for using the manual assessment method is £25 (plus \$4.38 VAT) for registration, marking and CPP certification.

CFor assistants who are not yet using Counterpart

If you have kept each complete Counterpart module to date (Pharmacist Briefing and Pharmacy Assistant Development Module), you may register your assistants on the course as in Section B (left).

For C&D subscribers who have not kept Counterpart, C&D will provide complete sets of back issues.

Charges

Sets of back issues cost \$15 (plus \$2.63 VAT).

Registration, administration charge and RPSGB levy \$20 (plus \$3.50 VAT)

Subscribers who have mislaid just one or two modules only should contact Tracy Mathews on 0181 747 8797.



Pharmacy.....

Pharmacist.....

Address.....

..... Telephone

Fax.....

Please list by name in alphabetical order the assistants you wish to register for Counterpart (see section B above)

If your assistant is using Counterpart, but is registering to use C&D's interactive telephone marking system (PIN) for the first time, please fill in the '\$ space' at the end of the name line with the fee (\$23.50, including VAT).

Name..... \$.....

Name..... \$.....

Name..... \$.....

Name..... \$.....

Name..... \$.....

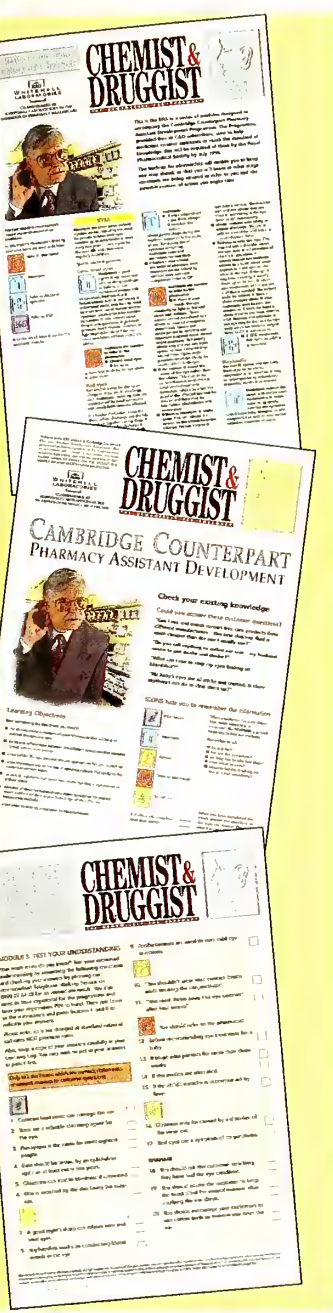
Name..... \$.....

Sub total \$.....

I subscribe to C&D at the above pharmacy address and need [] complete set(s) of back Counterpart modules 1-9 (\$17.63, including VAT) \$.....

Total \$.....

Cheques should be made payable to Miller Freeman Professional and sent to Sue Cheeseman, Pharmacy Group Special Projects, *Chemist & Druggist*, Sovereign Way, Tonbridge TN9 1RW.



tion? And what were to be the course guidelines? Partly due to a delay in publishing details of a revised NVQ knowledge base (and apparently to much internal wrangling), it was to be September before course providers knew the former, and mid-November before they knew the latter – by which time both of the new courses were halfway through!

What a mess. With a good track record in distance learning, the NPA had perhaps hoped to corner the market by getting in first: the Society, on the other hand, wanted to see competition in both providers and types of provision (C&D's telephone marking system won praise from the first day of launch, for example).

But when the College of Pharmacy Practice entered the scene as the accrediting body, it brought new educational demands to the table – demands which ran contrary to the views

of some experienced educationists involved in the courses. It is perhaps indicative of the change in the ground rules that not one of the seven courses submitted cleared the accreditation hurdle at the first attempt.

As the complexity of the tempting offers made to subscribers by C&D in this issue will testify, these delays have done nothing to help the profession meet its obligations in the shortest possible time.

Accreditation in summer, 1995, could have had the majority of assistants well on their way to fully-trained status, with catch-up modules being produced at the end of each course to take account of any NVQ syllabus changes. Instead, conscientious pharmacists were left to guess which courses to start – and most, not surprisingly, held back. We hope the Society and profession will not have cause to regret wasted opportunities.

Turn those complaints into a benefit

I have always felt that the complaints system within the NHS was cumbersome and weighted in favour of the professions. If the complaint was not an open and shut case involving a contractual breach, the chances of a satisfactory outcome were minimal. However, with the publication of the Wilson report and its implementation from April 1, all this is set to change. At last, the customer has a real chance to voice a genuine grievance, no matter how trivial, and will be entitled to see it dealt with sympathetically.

The new system is clearly and simply explained in a new booklet recently published by the NHS Executive and sent to all practising NHS pharmacists. I must admit to having been aware of the Wilson report without ever understanding its significance. However, this booklet explains the new procedures in simple language and even invites us to use the enclosed sample forms, either intact or adapted, as the basis of our own procedures. It just shows that government directives can be simply explained and I must congratulate the authors on their efforts.

As to the consequences of the new procedures, only time will tell, but perhaps the principles of this NHS initiative might be beneficially applied to the whole shop. I actually receive very few complaints, but rather than complacently assuming that this means that all my customers are happy, when I reprint my poster for public display, I intend including a paragraph inviting them to voice their complaints. Then, instead of aggrieved customers silently voting with their feet, the offer of constructive reconciliation could also retain their commercial goodwill.

Told you so!

I have previously criticised Panpharma for trying to sell a 100g size of Movelat OTC and,

Topical Reflections



despite its huge investment in advertising, that criticism was regrettably vindicated. Now the company has obviously considered the wisdom of my words, or could it be the sales figures, because it has launched a 40g pack which, given Movelat's prescription pedigree, should sell well.

The company has also taken the opportunity to discard its prescription packaging and market the brand in a new livery with an extended name. Excellent news, but what an expensive lesson! I only wish the marketing men of the pharmaceutical industry would sometimes listen to me because, unlike their advisers, my fees are very low!

European expansionism

Another bastion of British individuality has just fallen, with the recent harmonisation of European Community standards for condoms. No longer will the British male have to conform to the tight requirements of the old standard, but will be free to expand into the more

generous proportions now considered by Brussels to be appropriate for the whole of the EC.

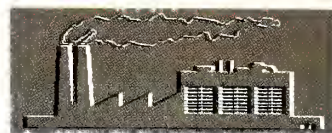
It seems that the new CEN (European Committee for Standardisation) specifications have increased the minimum allowable length and width of condoms in an attempt to reduce the incidence of splitting or falling off that, it is claimed, presently affects some 30 per cent of British male users. I am sure the European Committee has thoroughly researched the problem, but if its generosity comes as a relief to the 30 per cent, then it could be the return of the Wellington boot for some of the remainder. Perhaps condoms should, after all, come in different sizes, but then, if they were ever allowed on the Drug Tariff, 'measured and fitted' could take on a whole new meaning!

A note of caution

While on the subject of money, Whitehall Laboratories has just launched its multi-vitamin supplement, Centrum, in Britain. Whitehall is obviously convinced of its superiority over the opposition because the company has promised a colossal £3 million promotional spend. But, although Centrum is number one in the US, history teaches me that this is no guarantee of success in Britain.

The supplement market is still very specialist, expanding by virtue of designer products rather than broad spectrum multivitamins. I may be wrong, but I suspect that the extension of US statistics to the UK market may involve some painful financial lessons.

INDUSTRY VIEWPOINT



Search for added value

One of the bigger concerns for the Royal Pharmaceutical Society is what type of pharmacy the New Age should provide. Pharmacists have their own worries – decreasing fees, what role they should be adopting and rising competition.

The Department of Health has anxieties about whether pharmacists are adopting the correct function within a changing NHS. The problem is that no one within the Department can clearly state what that function is! Last, but not least, wholesalers and manufacturers are apprehensive in terms of who they will be service-

Retail pharmacy is no different from any other commercial activity

ing, market share, generics and brand substitution.

As far as retail pharmacy is concerned, it is not different from any other commercial activity – if you satisfy consumers better than your competitors, you will flourish – fail and you perish.

But what does satisfy the patient? One-stop shopping, 24-hour opening and access to specialist services are just a few items. Exceptionally good at providing these 'added values' are supermarkets. They regard pharmacy as adding value to their overall offering. It is no surprise that supermarket pharmacies are proving successful because of their convenience and long opening hours.

So how can community pharmacists compete? They can't! By trying to be supermarkets, they will end up with a 'me too', pale imitation! If they are to survive, they must discover their own 'added values'.

There is no single solution – each pharmacist must develop his or her own added value relevant to their local community. Rather than spending time worrying about many different factors, pharmacists should concentrate on solving just one problem – identifying added values that they can introduce to their business and getting on with introducing them!

This column is contributed by a senior industry manager.

Paracetamol suppositories

Arum Pharmaceuticals is launching Paracetamol Suppositories 240mg. The Pharmacy-only product is presented in packs of ten, with each mould identified with drug, strength and batch number for extra security on the ward. The basic NHS price is £9.25 for a box of ten. It will be distributed by: **Distriphar UK. Tel: 01895 837779.**

Dansac Unique Maxi

The Dansac Unique Maxi will be added to the Drug Tariff as from April 1, 1996. A pack of ten is priced at £21. **Dansac Ltd. Tel: 01223 235100.**

Generics promotion

Unichem is offering independents reductions of up to 56 per cent on key generic lines in a promotion which runs until March 29. The offer includes chloramphenicol eyedrops 10ml, hydrocortisone ointment 1 per cent 15g, ibuprofen tablets 600mg x 100 and nitrazepam tablets 5mg x 500. **Unichem plc. Tel: 0181 391 2323.**

Timoptol supplies

MSD is currently experiencing a short-term delay in the supply of Timoptol Unit Dose 0.5 per cent and 0.25 per cent due to delays in obtaining packaging components. The company is offering emergency supplies direct to pharmacists who urgently require them and will charge through the pharmacist's wholesaler account. Normal supplies of Timoptol 0.25 per cent and 0.5 per cent will be available from April 15 and April 22, respectively. **Merck Sharp & Dohme Ltd. Tel: 01992 467272.**

Entocort – new hope for Crohn's

Astra Pharmaceuticals is fighting back against Crohn's disease with the launch of Entocort CR, an oral formulation of the glucocorticosteroid budesonide.

It is indicated for the induction of remission in mild to moderate active Crohn's affecting the ileum and/or the ascending colon. This form afflicts over 70 per cent of the disease population.



The drug is held within a controlled ileal release formulation, consisting of a sugar core coated with a resin which delays release until it reaches the ileocaecal region. Although the exact mechanism of action is not fully understood, it is believed that Entocort has a local anti-inflammatory effect, with a similar efficacy to the standard steroid treatment for Crohn's disease, prednisolone.

However, Astra says budesonide is rapidly metabolised in the liver following absorption, with only 10 per cent remaining available systemically in healthy individuals, or 15-20 per cent in active Crohn's disease sufferers. Hence, budesonide has a 50 per cent less risk of inducing side-effects and

minimises adrenal suppression, when taken in comparison with prednisolone.

Dr Michael Kamm, consultant gastroenterologist at St Mark's Hospital, London, speaking at the press launch, said Entocort CR would be a suitable first-line treatment for those who cannot tolerate other steroids or who have poor bone density, which is worsened by steroids.

Astra has submitted a licence application for Entocort CR to be used as a maintenance therapy in Crohn's disease.

Dosage: 9mg (three 3mg capsules) once daily, before food in the morning, for up to eight weeks when the disease is in the active phase.

Packs and price: 100-capsule bottle, basic NHS price £90.

Product licence number: PL-0017/0359.

Astra Pharmaceuticals Ltd. Tel: 01923 266191.

Greater choice for chronic constipation

Norgine has introduced a new class of treatment for chronic constipation. Movicol contains polyethylene glycol 3350 and electrolytes (sodium bicarbonate, sodium chloride and potassium chloride) in a dry powder formulation.

Dissolving the contents of one sachet of Movicol in half a glass (125ml) of water provides a lemon and lime-flavoured, iso-osmotic solution, which effectively delivers a bolus of water to the colon. The water hydrates and softens the faeces, at the same time increasing the bulk in

the colon – a combination effect which facilitates the easy passage of soft stools. The recommended dose for adults is two or three sachets daily in divided doses, depending on the severity of the constipation. Elderly patients should initially be given one sachet daily.

Movicol is not absorbed by the body and the balanced solution ensures that there is no electrolyte imbalance, so dehydration does not occur.

Movicol is supplied in packs of 20 sachets at a basic NHS price of £9.85. Although the product is



a P line, Norgine is positioning it as a prescribable treatment for chronic constipation – a particular problem among the elderly, the disabled and patients receiving opiate therapy – and has no plans for consumer promotions.

Norgine Ltd. Tel: 01895 826600.

MEDICAL MATTERS

Inappropriate neuroleptic prescribing

The number of patients in nursing homes being prescribed potentially inappropriate and large doses of neuroleptics is a cause for concern, reports the *British Medical Journal*.

In the US, legislation, which included guidelines on the use of neuroleptics, was introduced in response to concerns about excessive intake of these drugs by residents of nursing homes.

Researchers in Scotland carried out a survey of neuroleptic

prescribing for over 900 residents of 28 Glasgow nursing homes and assessed the appropriateness of therapy following the American guidelines.

Almost one in four (24 per cent) of the residents were receiving regular antipsychotics. Applying the guidelines, 88 per cent could be regarded as receiving therapy for 'inappropriate' reasons, including mild aggression, agitation, wandering, uncooperativeness and insomnia.

Further findings revealed that, of the residents taking antipsychotics, 4 per cent were prescribed more than one and over a third (78 patients) were taking the equivalent of more than 50mg thioridazine daily.

The researchers say that these figures are a cause for concern, as long-term use of neuroleptics is associated with many problems, including an increased risk of hip fracture, increased constipation, impaired cognitive func-

tion, drug-induced Parkinsonism and tardive dyskinesia.

Age Concern in Scotland says that it is a major concern that such powerful drugs are being used to unnecessarily restrain elderly people. It suggests neuroleptics are being used to compensate for a lack of training in how to deal with challenging behaviour. The organisation is writing to all health boards in Scotland expressing its concerns over the findings.

Optrex to wake up eye care

Crookes is revitalising its Optrex range with a new look, which includes the lotion being repackaged in a clear glass bottle, as opposed to its traditional amber.

Across the range, the Optrex logo has been made more elliptical, which the company says helps to convey the eye care theme more strongly. Packs also now feature more consumer-friendly graphics to distinguish the different variants in the range, eg there is a 'splash' to indicate the Lotion, a daisy on the Hayfever Allergy Eye Drops and a drop motif on the Eye Drop products.

The range relaunch is also boosted with the introduction of a new product: Optrex Dry Eye Therapy Eye Drops. They contain 0.3 per cent hypromellose, a tear substitute that



relieves eye irritation and provides lubrication. They are to retail at \$3.10 and are available in a two-tier counter display unit holding 12 products. A customer information leaflet is also available.

At the same time, Clearine is being renamed as Optrex Clear Eyes Eye Drops, and Optrex Eye Masks have been updated with an upgraded material.

A \$3 million support

package backs the relaunch and includes the brand's first television advertising for four years.

Crookes is also initiating new merchandising, which incorporates a new flexible modular display system, including a stacking system for Hayfever and Dry Eye to avoid using excessive shelf space.

Crookes Healthcare Ltd.
Tel: 0115 9539922.

Scholl steps up footcare with £2.5m

Scholl is set to boost its 65 per cent share of the \$25.3 million footcare market by relaunching its Summer Footcare range. The relaunch includes the introduction of three new products, a pack redesign across the whole range and a \$2.5m national advertising campaign.

The new products are: Anti-perspirant Foot Spray (150ml, \$2.19), Odour Control Foot Spray, with extra strength (150ml, \$2.59) and improved Comfort Fresh Insoles, with a new top cloth and fragrance (\$1.85 per pair).

In the pack redesign, the traditional yellow and blue livery has been retained, but



now features additional colour-coding to clearly differentiate between the seven focal segments of the range.

The advertising campaign – which will not feature television – will break in May.

New point of sale material is available. ● Ian Kirsch, Scholl's marketing manager, says that the footcare market grew by 11 per cent in 1995, boosted by the hot summer.

Scholl Consumer Products Ltd.
Tel: 01582 482929.



You can counter on Medisport

Medisport is introducing a new counter display unit, allowing small pharmacies unable to hold its larger units to stock some of the leading products in the range.

A supply of easy to pocket tape measures is also available to help assistants in fitting the correct support.

The range is backed

by a national press campaign which continues into May. The outside back sports pages of *The Sun*, *Daily Express*, *Daily Star*, *News of the World* and *Sunday Express* will feature ads encouraging sportsmen to visit their local pharmacies for the range.

Medisport Helpline. Tel: 01730 231132.

Atlantis Lynx up with Systeme

Elida Fabergé is offering a free 100ml travel-size pack of Lynx Skin Systeme moisturising shaving gel with every purchase of the new Lynx Atlantis body spray.

The special banded packs are priced at £2.19. ● A new television and cinema campaign is

currently supporting Lynx which incorporates a new strapline, the 'Lynx effect'. It features a shy male at a party, transformed into a tango-dancing, smooth talker after having applied the new Atlantis variant.

Elida Fabergé. Tel: 0181 481 6000.

Complan opts for complete relaunch

Complan, the nutritional meal in a drink, is being relunched with a range reformulation, two new flavours, new packaging and a substantial support programme.

The reformulation has made the product easier to mix and has enhanced its flavour, says manufacturer Heinz. The six existing flavours (original, strawberry, chocolate, banana, vanilla and chicken) are being joined by peach & raspberry and vegetable.

Packs now feature brighter colours and graphics and are

available in cases of 12.

The relaunch is being supported by a \$650,000 promotional spend, which includes women's



press advertising.

Complan will also be promoted as part of Heinz's \$4.5 million direct marketing initiative, using its 'At Home' magazine for product sampling and couponing. ● **H J Heinz Company Ltd.**
Tel: 0181 573 7757.

Ramer introduces VIP trading

Ramer is introducing a new trading account, the Very Important Pharmacist (VIP).

The account offers several privileges including:

- 'top-up' stock which can be bought in (without regard to the normal minimum order)
- availability of free

literature and samples

- access to a certain number of 'seconds' in obsolete packaging at a discounted price
- advance information on promotions.

The new account coincides with Ramer's 50th anniversary. **Ramer Ltd. Tel: 01276 63192.**



New Easter variant for Olvarit

Cow & Gate Olvarit is introducing a new variety, Olvarit Easter Surprise, a chocolate pudding recipe aimed at babies aged from four months.

The new variant, launched especially for the Easter season, features a bright yellow label with spring chicks and eggs. A 150g jar retails at \$0.52.

Its introduction has been instigated by the success of the Olvarit Christmas Dinner recipe. **Cow & Gate Nutricia Ltd.**
Tel: 01225 768381.

THE MOST EFFECTIVE DANDRUFF SHAMPOO IS ONLY AVAILABLE FROM YOU

No 1 prescription treatment. Nizoral shampoo is the leading prescription treatment for dandruff, trusted by GPs and dermatologists alike for its efficacy and safety. Now its clinically proven formula is available without prescription as Nizoral Dandruff Shampoo; backed by the promotional investment to ensure commercial success.

Exclusive pharmacy opportunity. New Nizoral Dandruff Shampoo contains ketoconazole; which is more effective against the fungus that causes dandruff and seborrhoeic dermatitis than selenium sulphide, zinc pyrithione or tar. Yet it is gentle and odour-free. It is the most effective and pleasant treatment dandruff sufferers can buy - and they can only buy it from you.

£2,000,000 national launch. National TV, press and magazine advertising, plus PR and point-of-sale materials will be making sure sufferers get the message. As over 40% of the population have dandruff at some time, the sales potential is enormous. For one of the best pharmacy opportunities in years, recommend Nizoral Dandruff Shampoo.



First aid for dandruff

PRODUCT INFORMATION: **Presentation:** Pink, unperfumed shampoo containing ketoconazole 20 mg/ml. **Uses:** Prevention and treatment of dandruff and seborrhoeic dermatitis. **Dosage and Administration:** Adults, Elderly and Children: Wash hair and leave for 3-5 minutes before rinsing. For the first 2 to 4 weeks - use every three or four days to clear dandruff. Thereafter, use once every 1 or 2 weeks to prevent dandruff from coming back. **Contra-indications:** Hypersensitivity. **Precautions:** To prevent a rebound effect, withdraw topical scalp steroids gradually over two to three weeks, or as directed by your doctor or pharmacist. **Side Effects:** As with other shampoos, local burning, itching, irritation, oily/dry hair or increased hair shedding may occur but are rare. Rarely in patients with chemically damaged or grey hair, a hair discolouration has been seen. **Pregnancy:** Can be used during pregnancy and lactation. **Legal Category:** P. **Product Licence No:** 0242/0140. **Package quantities, Price:** 60 ml Bottle £5.45 (33% POR). **Date of Preparation:** December 1995. **Full prescribing information is available from licence holder:** Janssen-Cilag Ltd, P.O. Box 79, Sanderton, High Wycombe, Buckinghamshire, HP14 4HJ. Nizoral is a registered trademark.

NIZORAL™ Dandruff Shampoo
Ketoconazole

Johnson & Johnson MSD
CONSUMER PHARMACEUTICALS

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GIVING YOU THE POWER TO CALM THE FLOWERS

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1 OUTER = 12 RETAIL SINGLES

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NATIONAL TEL: 0500 525381 FAX: 01903 216008
NORTH EAST TEL: 0800 590102 FAX: 0191 4100133
NORTHERN IRELAND TEL: 0800 212697 FAX: 01574 274405

SEE YOUR LOCAL REP/TELESALES GIRL FOR FURTHER DETAILS.

Miles ahead

Herbalforce Natural Products has teamed up with the Miles Group to expand its distribution in the pharmacist sector. **Herbalforce Natural Products Ltd. Tel: 01666 505025.**

Palmer's on the move

E T Browne has moved to: **Cambrian House, 509-511 Cranbrook Road, Gants Hill, Essex IG2 6EY. E T Browne (UK) Ltd. Tel: 0181 554 7000.**

Dermablend demo

Dermablend is giving a demonstration of its Cover System (for cosmetic camouflage) to the Dudley and Stourbridge branches of the RPSGB on April 16. Further details from: **Mrs Hasslewood on 0121 602 1193.**

Unichem in Fuji deal

Unichem is offering Fuji film at a reduction of up to 48 per cent. The offer will run from April 1-30. **Unichem plc. Tel: 0181 391 2323.**

Predictor party

To coincide with Predictor's silver anniversary, new point of sale material (including shelf edgers, show cards and window stickers) is now available. Chefaro is also running an ongoing scratch card promotion for pharmacy staff with prizes of up to £1,000. **Chefaro UK Ltd. Tel: 01223 420843.**

Amberwood move

Natural healthcare publisher Amberwood Publishing has moved. The new address is: **Braboeuf House, 64 Portsmouth Road, Guildford, Surrey. Tel: 01483 570821.**

Oil of Ulay packs

A small number of 15ml Oil of Ulay Eye Contour Gel jars have been found to be defective, with fragments breaking away from the rim on opening. Questions or refund requests should be addressed to: **Procter & Gamble. Freephone: 0800 708708.**

Dentazyme toothpaste debuts in UK

Dentazyme is a new toothpaste heralding from South Africa through Dentacare Products.

Available in two flavours, Cinnamon and Citrus Mint, the paste is approved by the British Dental Foundation and the Vegetarian Society, as it contains no animal fat derivatives. It is also Halal certified.

Dentacare believes that this animal fat-free positioning is a key



selling point given that 8.5 million people in this country are either vegetarian or hold religious beliefs that do not approve of the use of animal fats.

The 100ml tube retails

at \$1.69 with an introductory price of \$1.29, while the 50ml tube retails at \$0.89 with an introductory price of \$0.69.

Dentacare Products Ltd. Tel: 0116 253 3371.

Sun care training pack from E45

'Learn to live and work in the sun' is a new information pack from E45.

Designed to be used by health professionals, the pack is aimed at adults and children, and includes individual presentation

questionnaires, advice leaflets, topical fact sheets, sun care posters and Sun E45 samples.

It is available to pharmacists at a cost of \$15 from: **Sun E45 Sun Care Pack, PO Box 193, Nottingham NG3 2HA.**



Eucryl's money-back guarantee

Eucryl tooth stain remover is offering a money-back guarantee to any unsatisfied customer.

The 'Whiter than white money-back guarantee' promotion is currently on-pack.

If the buyer does not believe that it has removed tobacco stains more effectively than other smokers' products, then a full refund can be claimed.

Refunds can be obtained by returning the product, with proof of purchase, to the address shown on the promotional box – not through the retailer.

LRC Products Ltd. Tel: 01992 451111.

Colgate gets striped for action

Colgate Triple Cool Stripe Gel is the latest addition to the Colgate toothpaste range.

The white paste has a deep blue and a turquoise stripe running through it, which Colgate says "marries modernity and fun" with the cavity-fighting reassurance of the Colgate name.

The new variant replaces Colgate Blue Minty Gel and has an rrp of \$1.49 for the 100ml tube and \$0.85 for the 50ml tube. A 100ml pump version is to be introduced in April.

To encourage trial, packs of Colgate Blue Minty Gel are currently carrying a consumer money off next purchase coupon for Colgate Triple Cool Stripe Gel. **Colgate-Palmolive Ltd. Tel: 01483 302222.**



SB boosts oral care range

Smithkline Beecham is launching a 600ml size of its Corsodyl Mouthwash, in line with its recommended course of treatment for gingivitis.

The new size is in its mint variant and will retail from the end of March at \$7.20.

SB is also running a free toothbrush promotion on its Aquafresh brand.

From March 22, Aquafresh 100ml toothpaste pumps will have a free Aquafresh Flex 'n' Direct toothbrush attached. The promotion coincides with a fresh burst of television advertising for the paste.

SB is also currently backing its Macleans Mouth Guard in a \$1 million TV campaign. **Smithkline Beecham Consumer Healthcare. Tel: 0181 560 5151.**

Rowenta bolsters its dental offering

Rowenta is launching a new selection of oral care products – at prices significantly lower than other players in the market.

First up is Dento, a series of battery-operated toothbrushes for adults, priced at \$19.99. The brush has an elliptical movement and angled head.

To encourage children to brush their teeth, and to introduce a new sector to the electrical market, is Dentiphant (\$17.99) – the first battery-operated toothbrush for children (aged three years and over). Available in bright pink and bright blue, the Dentiphant comes with five cartoon stickers for decoration (so that they can be personalised).

To the rechargeable market Rowenta adds new Multi Plaque Dentacontrol (\$54.99). It has a capacity of 10 minutes' brushing time and comes with a series of different brush heads. **Rowenta. Tel: 01372 277511.**

Hydration-Plus adds SPF

Clarins is introducing a second formulation in its Hydration Plus Moisture Lotion, this time with a sun protection factor of 15.

It is designed for daily use with specific benefits for consumers who are sun-sensitive. It is presented in a 50ml pump action bottle and retails at £19. It will be available from mid-May.

Clarins (UK) Ltd. Tel: 0171 629 2979.

Saying aloe to after sun

Banana Boat is adding a new Aloe After Sun Spray to its sun care line-up this year.

Presented in a non-aerosol pump plastic bottle, the cooling spray is for use during or after sun exposure. It has a non-sticky formulation and a vanilla fragrance.

It retails at \$3.99 for a 236ml bottle.

Clarrell International Ltd. Tel: 01732 740242.



Tone up with Blistex

Dendron is extending its lipcare range with the introduction of Blistex Lip Tone.

The stick has an SPF 15 and contains four plant extracts known for their moisturising properties: aloe extract, almond oil, calendula oil and rhatania root

extract. It also includes an amino/vitamin compound, containing vitamins A and E.

Blistex Lip Tone retails at £1.99 and is packed 12 to an outer, which acts as its own POS.

Dendron Ltd. Tel: 01923 229251.



Women get fit with Polo Sport

This June will see the UK launch of Ralph Lauren Polo Sport Woman.

Described as a fitness fragrance, it's not just a female rendition of the men's product, says Rod Kelly, managing director of Prestige & Collections. With men, he says, sport comes first, fitness second, while with women it's fitness first and sport as a means to that end.

This fitness emphasis reflects the ethos of the new fragrance.

The scent itself opens up a possible new category, being a cool-translucent-floral. Top notes include water mint, citrus and tiger melon, with heart notes of

California poppy, freesia, wild ginger and nutmeg. Base notes are woody with white musk, river maple and sandalwood.

Elegantly packaged in clear bottles and white tubes, there are six skus in the range: eau de toilette spray (100ml and 150ml, \$27.50 and \$37.50 respectively); Scrub foaming sea salts (200ml, \$15); Cleanse, a moisturising spa wash (200ml, \$15); Hydrate, a gel body moisturiser (200ml, \$15); Sculpt, a dry oil body spray (100ml, \$17.50); and Finish, a 'coolness' body spray (150ml, \$22.50).

Prestige & Collections Ltd. Tel: 0181 979 6699.

Agfa camera makes APS easy

With the Advanced Photo System due out in the market at the end of April, Agfa is paving the way for unsure consumers with the introduction of a new reusable camera, the Agfa Easy.

With pre-loaded Agfa Futura 400 film, the Agfa Easy offers two image formats – High Definition and Panorama – for each exposure. The resultant prints are accompanied by an index print of the 25

photos, as well as the negatives in the film cassette.

But the innovation doesn't end there. The camera also has a protective shell which enables it, once returned to the manufacturer, to be fitted with a new film and shell, ready to be used again.

Retail prices are still to be decided.

Agfa-Gevaert Ltd. Tel: 0181 560 2131.

Mum's Botanical inspiration

Bristol-Myers has extended Mum deodorant to a new sub-range, Botanicals by Mum.

Botanicals is a new female anti-perspirant deodorant line, with a 'Deo-Botanical complex' of aloe vera, jojoba and calendula. Natural essence fragrances complement the concept: Sundew, Laurel and Cassia.

The pack design uses botanical imagery on a white background with a silver detail and a colour cue to identify each variant. All have a green cap. The 150ml aerosol will retail at \$1.89 and the 50ml roll-on at \$1.29.

The launch is to be supported by a \$3.5 million advertising and promotional campaign. **Bristol-Myers Co Ltd. Tel: 01895 628000.**

Shock treatment

As part of the relaunch of its nail care range, Bourjois is introducing three new treatments: Base Haute Protection, Durcisseur Eclat and Fini Parfait. All retail at £3.50.

Shock-Resistant is now enriched with vitamin B5 and is presented in a bottle with a matt gold cap. Retailing at £3.25, there are ten shades.

Fortifiant nail colour is available in four sheer shades and presented in a frosted bottle with a white cap. It retails at £3.50.

Bourjois Ltd. Tel: 0171 436 6110.

Stay put with L'Oréal

This month sees the introduction of what L'Oréal says is the biggest-ever lipstick breakthrough.

Colour Endure in the L'Oréal Perfection range is a lip colour with both long-lasting benefits and caring properties. Its formulation combines ultra-concentrated pigments and oils: when the colour goes on the lips, the oils evaporate, 'locking' the colour in place.

Fifteen shades are available and retail at \$4.99.

L'Oréal. Tel: 0171 937 5454.

ON TV NEXT WEEK

Bazuka Gel: C4

Clairol Ultress: All bar GTV, U, HTV, LWT, C4 & GMTV

Colgate Toothpaste: All areas

Cow & Gate Step-Up Follow On Milk: STV, G

Gillette Sensor for Women: All areas (not satellite)

Halls Soothers: All areas

Ibuleve: U, WCTV, A, M, HTV, S, G

Johnson's Baby Bath: All areas

Lil-lets Applicator: All areas

Neutrogena Norwegian Handcream: All areas

Neutrogena T-Gel Shampoo: All areas

Nurofen: All areas

Otex: C4

Pepto-Bismol: All areas except Y, TT

Sanatogen Gold: All areas except GTV, HTV, TSW

Sensodyne: All areas

Wrigley's Sugar Free: All areas

GTV Grampian, **B** Border, **BSkyB** British Sky Broadcasting, **C** Central, **CTV** Channel Islands, **LWT** London Weekend, **C4** Channel 4, **U** Ulster, **G** Granada, **A** Anglia, **CAR** Carlton, **GMTV** Breakfast Television, **STV** Scotland (central), **Y** Yorkshire, **HTV** Wales & West, **M** Meridian, **TT** Tyne Tees, **W** Westcountry



RELIEVE THE ITCHING AND IRRITATION OF ECZEMA

PRODUCT INFORMATION: CREAM E45: White bland emollient cream which contains white soft paraffin BP 14.5% w/w, light liquid paraffin Ph Eur 12.6% w/w and hypoallergenic anhydrous lanolin 1.0% w/w. **Uses:** For the symptomatic relief of dry skin conditions, where the use of an emollient is indicated, such as flaking, chapped skin, ichthyosis, traumatic dermatitis, sunburn, the dry stage of eczema and certain dry cases of psoriasis. **Dosage and administration:** Apply to the affected part two or three times daily. **Contra-indications, warnings etc:** Cream E45 should not be used by patients who are sensitive to any of the ingredients. **Packaging quantities:** Tubes containing 50g, tubs containing 125g and also 500g. **RSP:** Tube 50g £1.75. Tub 125g £3.55. Tub 500g £8.35. **Legal category:** GSL. **Product licence number:** PL 327/5904. **Product licence holder:** Crookes Healthcare Ltd., Nottingham NG2 3AA. **Date of preparation:** October 1995. **Hc45 HYDROCORTISONE CREAM:** Smooth white cream containing hydrocortisone acetate BP 1% w/w. **Uses:** For the relief of mild to moderate eczema, irritant and allergic contact dermatitis and insect bite reactions. **Dosage and administration:** Apply sparingly to a small area, once or twice a day, for a maximum of seven days. **Contra-indications, warnings etc:** Hc45 should not be used on the eyes or face, the ano-genital area or on broken or infected skin, including impetigo, cold sores, acne or athlete's foot. The product should not be used in pregnancy or in children under 10 years without medical advice. **Packaging quantity:** Tube containing 15g. **RSP:** £2.55. **Legal category:** P. **Product licence number:** PL 0327/0039. **Product licence holder:** Crookes Healthcare Ltd., Nottingham NG2 3AA. **Date of preparation:** October 1995.



You can't recommend a more effective way than 1% hydrocortisone to relieve the inflammation of mild to moderate eczema and contact dermatitis. And Hc45, the leading 1% hydrocortisone in pharmacy for years, is the ideal complement to emollient therapy.

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sodium alginate/cimetidine

ECLIPSES EXISTING RAFTING AGENTS



*An independently conducted survey of 214 general practitioners conducted in October 1995!

Tagamet Dual Action Liquid. Product Information: Presentation. A white suspension with an odour of fruit and mint containing 500 mg sodium alginate B.P.C. and 200 mg cimetidine per 10 ml dose. **Use.** Short term symptomatic relief of heartburn, associated with acid regurgitation, especially if provoked by bending over or lying supine.

Dosage and administration: Adults (incl. the elderly), children 16 years and over, 10 ml suspension when symptoms appear. If symptoms persist for more than 1 hour after the first dose, a second dose (10 ml) may be taken, but no more than 2 doses in any 4 hours and no more than 4 doses in any 24 hours. Treatment should not be continued for more than two weeks. If symptoms persist for more than two weeks or recur regularly, a doctor should be consulted. Not to be given to children under 16 years of age.

Contraindications. Hypersensitivity to cimetidine or any of the other constituents.

Precautions. Not recommended in patients with impaired renal function, hepatic impairment, taking oral anticoagulants, phenytoin, theophylline, intravenous lignocaine; middle aged or older patients with new/changing dyspeptic symptoms, any patients with unintended weight loss and dyspeptic symptoms, because of potential delay in diagnosis of gastric cancer; with compromised bone marrow; in pregnancy and lactation. Use only on a doctor's advice in patients with any other illness, using any medication, under medical

supervision for other reasons, with a history of peptic ulcer who are now using NSAIDs especially the elderly. Contains 66 mg sodium per 10 ml dose and this should be included in the daily allowance of patients on sodium restricted diets. **Adverse reactions.** Diarrhoea, dizziness, rash, tiredness, Gynaecomastia, occasional liver damage, confusional states (usually in the elderly or very ill), all reversible. Rarely thrombocytopenia, leucopenia, agranulocytosis all reversible. Very rarely, hepatitis, interstitial nephritis, acute pancreatitis, headache, myalgia, arthralgia, fever, sinus bradycardia, tachycardia and heartblock, all reversible, aplastic anaemia, pancytopenia and anaphylaxis. Reports of alopecia and very rarely reports of impotence but no causal relationship has been established at usual prescribed therapeutic doses. **Product licence number** 0002/0232. **Retail price** (200 ml) £4.99. **Legal category** P. **Date of preparation** 8 June 1995.

Reference 1. Taylor Nelson AGB plc Omnimed 1995.

SmithKline Beecham Consumer Healthcare,
SB House, Brentford, Middlesex, TW8 9BD.
Telephone number 0181 560 5151.
"Tagamet" is a trademark.

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PHARMACYupdate

Team working

Multi-disciplinary team working is the way forward for pharmacy /

Psoriasis

It affects 1,500,000 in the UK, but its causes are unknown /V



Research Digest

The link between drugs and falls in the elderly investigated /V



The dream team

In the first of a two-part series, **Dr Maureen Devlin**, customer manager (for pharmacy) at Glaxo Wellcome, examines multi-disciplinary team working

A 'multi-disciplinary' approach does not just apply to healthcare, almost anywhere you look there are examples of this approach to problem-solving or just 'getting things done in the most effective manner'.

So who should make up a multi-disciplinary team (MDT) in the provision of healthcare? It will depend on the particular case, patient, disease area or situation concerned. The skills needed to manage an asthmatic in the community will differ from those required to care

for an elderly, diabetic cardiovascular patient. Different professionals are required to manage the two types of patient due to the nature of the illness and the circumstances of the patient.

The theory of multi-disciplinary working can, however, be less than easy to achieve in practice. Problems and difficulties can occur, when there is an inappropriate skills mix, or when barriers are allowed to prevent the process working.

Key issues

The community pharmacist may face more obstacles than other professionals in order to use his/her skills in a multi-disciplinary environment.

Historically, informal MDTs have existed in primary care, usually comprising the GP, practice nurse, district nurse and health visitor. The community pharmacist may have interactions with each of the above individuals, but rarely

at the same time. The perceptions of each health professional of one another in this instance will probably be very different.

For a true MDT to form, regular group meetings are needed to discuss treatment and management options.

In order for the community pharmacist to overcome real or perceived barriers, it is important to consider a number of key issues.

● Do you want to become more involved?

If not, don't do it! Commitment and enthusiasm are vital for the team to work. However, think about why you don't want to be involved. Fear? Increased workload? Financial concerns? Lack of confidence? Don't know where to start? Identifying the problem is the first step to finding a solution.

● Don't take any initial difficulties personally

Do your colleagues have a good understanding of your

training and knowledge? Are they aware of your counselling skills or home delivery service?

Learn to sell yourself – get to know all the parties involved in an area you are interested in (eg asthma, diabetes). Invite yourself to any joint or surgery meetings to get you started.

Remember, your contribution to any team will be unique – an understanding of therapeutics, of compliance and the ability to identify the danger signals of inappropriate treatment.

● Do you fully understand the skills and remit of the other professionals in your area?

Find out who they are and what they do – it will help to identify how you can bring your skills to the team.

● Talk to colleagues already involved

Talk to any pharmacists involved in published clinical projects, and local hospital colleagues. A MDT approach to patient management is well established in hospital practice. In the US and pilot hospitals in the UK¹ satellite pharmacies operate at ward level, and the team thus comprises the doctors, nurses, therapists and pharmacists dealing with those patients. The links into the community are also well established to ensure continuity of care under the appropriate colleagues after discharge.

● Does my location matter?

Clearly, there are inherent advantages for those pharmacists situated within a health centre. But this does not mean that good collaborative relationships can't and don't already exist between pharmacists and their local surgeries, either with all members there, or with some individuals. Many pharmacists additionally are integrated into the team looking after patients in nursing homes.

Inclusion into MDT is not a right, but it is hard to see

Continued on P11 ►

Team working

Why?	How do teams add value?	What about the individual team?
Effective teams can produce significantly better outcome than the sum of individuals 1+1=5	Teams can produce a superior outcome faster than individuals – better for the patient	Opportunity to learn from colleagues – aids own professional development
Effective team working can prevent duplication	Teams provide the vehicle for bridging professional boundaries and creating new ways of working (processes)	Allows the individual to use their skills/expertise
Minimises waste of resource (team and money)	Teams facilitate learning	—

The benefits of a multi-disciplinary approach

Patient	Healthcare professionals	NHS/Government
The right care at the right time by the right person	Recognition and respect of colleagues	Effective use of cash from local budgets
Prevents duplication of effort	Ability to use skills to best effect	Effective use of skills – pay for the right skills when needed
Minimise 'gaps' in patient care	Valued as member of professional team	Better patient outcomes
Crises can be recognised and dealt with more efficiently	Facilitates learning	Promotion of community-based care in line with Government strategy
Feel included, more in control of their condition	Aids professional development Increased job satisfaction Extension of traditional role Share in successes Reduces professional misunderstandings	

Continued from PI

when a community pharmacist could not make a valuable contribution to the management of patients in the community.

Barriers

There are several barriers which have to be considered.

● Poor communication

Honest and open communication thrives in a climate of trust. Steven Covey² describes a model of trust, communication and co-operation in Figure 1.

The lowest levels of communication coming out of low trust situations would be characterised by defensiveness and protectiveness.

Respectful communication will be based on mutual intellectual understanding, but avoidance of any confrontation may result in polite rather than empathetic communication. It is honest and genuine, but doesn't facilitate new ideas or creativity.

True synergy between different individuals (win/win) comes with high levels of trust and co-operation: the ideal for any MDT.

● Knowledge or skill

Another barrier is knowledge (the understanding of a subject; learning) or skill (requires knowledge/use of knowledge).

In other words it is not what you know, it's how you use it!

● Respect

Respect has to be earned both for you and by you. In a team situation it is important to respect the individual but not to be afraid to challenge an idea. Respect someone not understanding – they are open to learn.

● Dominance

Effective team working depends on the ability of the team leader to ensure that everyone in the team feels valued and able to make contributions when it is relevant.

Team members also have a responsibility to give and receive feedback on how they contribute to the team – it is important that feedback concentrates on behaviours rather than personalities.

Suggest that the chairmanship of each meeting is undertaken by different members in rotation and always be prepared to listen when others are speaking; you want them to listen to you.

Funding

Community pharmacists' remuneration does not make provision for time away from the pharmacy, either within the surgery/health centre for meetings or for domiciliary visits when a locum must be found and paid for. But where and how can this be achieved?

● Health authorities

A number of FHSAs and

Figure 1: communication model



health boards are paying pharmacists for their involvement in prescribing initiatives. As a protocol in essence includes who does what, when and how, there is an obvious progression for the pharmacists into the team working to that protocol.

● GP fundholders

GP fundholders have been employing pharmacists for some time on an ad hoc or more formalised basis to offer prescribing advice. This climate of trust and respect allows the pharmacist to broaden his/her involvement in the practice, possibly including other community colleagues with different skills and interest.

● Pharmaceutical industry

The pharmaceutical industry is expert in the therapy areas relevant to its products. Many have developed protocols for the management of conditions which are specific to the needs of the pharmacist, and can facilitate discussions with other health professionals.

Surgery meetings organised or sponsored by medical representatives are an ideal basis for building relationships which may result in project sponsorship.

If you believe your professional and commercial survival calls for you to become more

involved in patient management as part of a recognised team, you may have to invest some of your profits into building up yourself as a business asset. Engage a locum for a week while you go out and make your contacts. In other words: **invest in yourself.**

Patient anxiety

Patients are bound to be anxious and reassurance must be given regularly to both them and their family that the reason they may see different professionals is that that particular professional is able to do what is best for them at that particular time.

The first briefing should come from someone they trust – the advantages of being looked after by a group of skilled people will soon become evident.

In summary, taking a MDT approach to the management of patients is the only way forward within an NHS that is constrained by budget but with a desire to improve patient outcomes.

A summary of the benefits for all involved is:

● Why

– patient benefits from best practice

– effective use of skills and resources

● When

– if benefit can be gained – different discipline

● Who

– case/therapy dependent
– team comprising appropriate skills mix
– driven by the team

● How

– effective team working
– clear objectives and focus
– audit and review
– across professional boundaries.

References

- 1 St Helier Hospital, Carshalton (PJ Vol 255; Nov 11, 1995; p644)
- 2 The Seven Habits of Highly Effective People, Stephen R. Covey ISBN 0-671-71117-2.

*The practicalities of adopting a MDT approach will be covered in the next **Pharmacy Update**.*

THE NEW ONCE-DAILY TREATMENT FOR PSORIASIS

EFFECTIVE

Significant overall improvement was noted after just 2 weeks of therapy¹

ONCE DAILY

One application lasts from one night-time application to the next, facilitating better compliance

ALL OVER TREATMENT

Can be used all over the body - even on the face and flexures



Prescribing Information

Curatoderm Ointment 4µg/g contains tacalcitol monohydrate 4.17 µg/g (tacalcitol 4µg/g). Other ingredients: white petrolatum, liquid paraffin, diisopropyl adipate. **Indication:** Psoriasis vulgaris. **Dosage:** Adults and the elderly: Apply sparingly, once daily to the affected areas, preferably at bedtime. The amount applied should not exceed 5g of ointment/day. Normally duration of treatment should be no more than two courses of 8 weeks duration each year. Children: not recommended. **Contraindications:** Hypersensitivity to constituents; in patients with hypercalcaemia or other known disorders of calcium metabolism. **Special warnings and precautions for use:** In patients at risk of hypercalcaemia, albumin corrected serum calcium levels should be closely monitored. Treatment should be stopped if hypercalcaemia occurs. Serum calcium levels should also be monitored in patients with renal impairment. Curatoderm is not recommended for use on the scalp. Care should be exercised in patients with generalised pustular or erythrodermic exfoliative psoriasis as the risk of hypercalcaemia may be enhanced. When applying to the face avoid contact with the eyes. Patients should be advised to wash their hands after applying the ointment to avoid inadvertent transfer to other parts of the body. **Interactions:** No interactions are likely in patients using multivitamin preparations with up to 500 IU vitamin D. When combining UV-treatment with tacalcitol topical therapy, UV-light should be given in the morning and tacalcitol at bedtime. When patients are likely to be exposed to sunlight, tacalcitol should be applied at bedtime. **Pregnancy and lactation:** Safety in pregnancy has not been established. Avoid use in pregnancy unless there are no safer alternatives. During lactation the breast area should not be treated. It is not known whether tacalcitol is excreted in breast milk. **Undesirable effects:** Local skin reactions (itching, erythema, burning, paraesthesia) have been reported. When they do appear they are usually mild and transient and seldom lead to treatment interruption. Other local reactions may occur. **Overdose:** Application of excessive amounts may lead to hypercalcaemia. Curatoderm, other vitamin D related products or calcium supplements must be stopped until serum calcium returns to normal. **Presentations:** Curatoderm is available in aluminium tubes containing 30g, or 60g ointment. Basic NHS price £15.09 for 30g and £26.06 for 60g. **Authorisation Number:** MA11648/0019. **Legal category:** POM. [®] Curatoderm is a registered trademark of Hermal. **Date of preparation:** December 1995. **Reference:** 1. Gerritsen MJP *et al.* (1994) *Brit J Derm* 131: 57-63.



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THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 10), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D*, APRIL 13, PROVIDES 1 HOUR OF CONTINUING EDUCATION CREDIT

OBJECTIVES

- To recognise who is affected by psoriasis
- To be aware of possible aetiology
- To differentiate the types
- To list treatments and understand their drawbacks

Psoriasis is derived from the Greek word, psora, meaning 'to itch', and affects 2-4 per cent of the white population¹, although among blacks incidence is lower².

It can affect anyone at any time, but is very rare below the age of five years. Onset is usually slow and normally occurs between the ages of ten and 50, with a peak around puberty and two lesser peaks around the ages of 30 and 50². The patient will suffer from chronic outbreaks and remissions; complete remission is rare.

The disease is characterised by erythema, scaling and thickening of the epidermis. Itchiness is sometimes present, too. The most commonly affected sites are on the knees, elbows, the scalp, the back and the buttocks. The face is often unaffected.

Put simply, psoriasis is due to the skin's normal replacement process being raised up to tenfold. The granular layer is reduced and keratin builds up in the stratum corneum. Dermal papillae swell from oedema and capillaries dilate. Micro-abscesses form as white blood cells infiltrate the stratum corneum³.

Aetiology

The causes of psoriasis are not fully understood, but there is a genetic influence:

- if one parent is affected, there is a 25 per cent chance the child will also be affected
- if both parents are affected this rises to 60 per cent
- if a sibling has psoriasis, there is a 30 per cent chance of another sibling also developing psoriasis⁴.

Skin deep

Psoriasis is one of the most common skin complaints affecting one and a half million people in the UK. **Charles Gladwin** examines the causes and treatments



Picture courtesy of Leo Laboratories

T-cells can be determined at affected sites, indicating psoriasis is an immune-related disorder⁵. US researchers have found IL-2 fusion toxin, which targets activated T-cells, returns the abnormally high number of T-cells at psoriatic sites back to normal, giving significant disease improvements.

Other studies suggest that histamine is involved in the pathogenesis of psoriasis⁶. Ranitidine, cyclosporin and methotrexate, all inhibit histamine release and have been used successfully to treat the condition.

Work is also looking at arachidonic acid and its inflammatory metabolites⁴.

Trigger factors

The following can trigger psoriasis at any time, whether it is the first incidence or after a period of remission:

- *Streptococcal* throat or upper respiratory tract infections can precede an outbreak of guttate psoriasis,

particularly in children

- exposure to the sun (in 10 per cent of sufferers) and severe sunburn aggravate psoriasis

- trigger drugs include chloroquine, lithium, beta-blockers, chlorpropamide, interferon-alpha and the withdrawal of systemic corticosteroids. Potent topical psoriasis may result in rebound psoriasis when withdrawn

- extreme stress, such as a bereavement or marital problems, is often associated with a first psoriatic episode. Stress or the anxiety of having psoriasis, often triggers or worsens psoriatic conditions

- nutritional states possibly have an effect
- smoking and alcohol may be trigger factors, a link has been established to localised palmo-plantar pustular psoriasis.

Initial diagnosis is best done by the patient's GP. It is unusual to see new cases in

the pharmacy as psoriasis often has a long onset time. And pharmacists should be aware that it can also be mistaken for other conditions, such as^{1,5}: eczema, tinea infection of nails, ringworm, allergic reactions, intertrigo, nappy rash, squamous cell carcinoma or localised scratch dermatitis.

Treatment

Treatment falls into several areas, from lifestyle management to severe hospital regimens. More severe treatment should be aimed at avoiding serious flare-ups. Side-effects can be reduced by a combination of several therapies at lower strengths or doses.

It is important that the patient understands the chronic nature of the disease so they will not be disheartened and cease therapy.

By keeping a diary, the patient may be able to identify and avoid times when the psoriasis flares up. Similarly, if flare-ups occur with certain foods, a food diary may help identify causes.

Avoiding skin irritants, eg wearing rubber gloves when working with detergents, may ease conditions. Cotton or silk underclothes may be more comfortable.

Topical therapy

Topical therapy tends to be for mild to moderate cases and is suitable for initiation by the GP. Treatment normally progresses from mild to aggressive, depending on how the psoriasis responds.

- **Emollients.** These do not control psoriasis, but ease the discomfort of dry scaly skin and can be used freely. However, certain ingredients, such as lanolin, may cause sensitisation.

- **Salicylic acid** This enhances the rate of loss of surface scale. Starting with concentrations of 2 per cent, applications can be increased

Types of psoriasis

- **Guttate psoriasis** – this is often the first form of psoriasis experienced, most commonly in children. Its name comes from the drop-like appearance, with the body (except the palms and soles) 'sprayed' with lesions. It can follow a streptococcal infection, in which case it erupts a week later. If treated successfully and early, 50 per cent of sufferers do not have another attack, but it often leads to chronic plaque psoriasis
- **Plaque psoriasis** – also known as psoriasis vulgaris, it is the most common form, accounting for 90 per cent of cases and is often chronic. It appears as red, scaly, sore, sometimes itchy patches with sharp, defined edges. Plaques appear mainly on the knees, elbows and scalp, but the groin and ears may be affected. Silvery scales on the plaques are easily shed. It can be very uncomfortable if it is on the hands or feet
- **Flexural psoriasis** – this often occurs with plaque psoriasis, and affects the major body folds, usually in older patients. Due to rubbing and occlusion of the sites, there are no silvery scales, but it has a 'glazed' appearance
- **Pustular psoriasis** – this appears as a mass of pustules on the palms or soles, or may be generalised, and can be very uncomfortable. It can result after long topical steroid treatment but is sometimes seen with chronic plaque psoriasis. The generalised form needs urgent GP referral
- **Scalp psoriasis** – this can appear as dandruff at first, but plaques will form. The edges of plaques may extend below the hair line
- **Nails** – changes occur with other psoriasis types, especially scalp psoriasis, and are common in the elderly. The nail may be pitted, start to separate from the nail bed (onycholysis), or may come off. Often only one or two nails are affected, but affected nails are prone to fungal infections
- **Erythrodermic psoriasis** – a very rare progression of chronic plaque psoriasis in which large areas of skin become inflamed and scaly, and is accompanied by fever, shivering and malaise. Emergency treatment may be needed
- **Napkin psoriasis** – similar in appearance to nappy rash, this extends into skin folds and tends to be asymptomatic. It often develops later into true psoriasis
- **Psoriatic arthritis** – occurs in up to 20 per cent of psoriasis sufferers and mainly affects joints in the fingers and toes and the spine

to 6 per cent. Other anti-psoriatic ingredients, such as dithranol or coal tar, are more usually combined. Preparations should be used with care on the extremities of diabetics or patients with poor peripheral circulation, and may cause contact dermatitis on healthy skin. Extensive and prolonged use of salicylic acid can cause systemic problems so should be avoided in asthmatics⁶.

● **Tars and tar oils** Due to their messy nature, these are not well tolerated. Refined coal tar products cause less staining of skin or clothing, but are not as effective as crude tar products.

Coal tar is believed to inhibit DNA synthesis and reduce epidermal thickness. It is suitable for chronic plaque psoriasis, and tends to be used in strengths of 0.5–1 per cent crude coal tar, although 10 per cent strengths may be used if upped in gradual increments. It may not work as fast as other treatments but offers longer periods of plaque-free remission.

Ung Coccois Compound may help lift scalp lesions.

● **Dithranol** This is an anti-mitotic so decreases the rate

of skin proliferation, but is very irritant on healthy skin. It is normal to start with a low-strength cream, such as 0.1 per cent, and double up gradually to about 5 per cent, or until skin irritation is unacceptable. It should not be applied to the face or genitalia.

Dithranol will stain skin, hair and clothing, but this can be reduced by adding salicylic acid to the preparation.

● **Topical corticosteroids** Corticosteroids suppress the immune response and modify inflammatory pathways, factors which seem to influence psoriasis. However, the *British National Formulary* advises that these should be avoided or given only under specialist supervision as 'relapse or vigorous rebound occurs on withdrawal'.

In reality, patients may want, and expect, to use potent steroids rather than have an outbreak of psoriasis, so seemingly excessive prescribing may occur.

Use should be kept to a minimum to reduce side-effects, including local skin thinning, and systemic effects, including Cushing's syndrome and osteoporosis.

Steroids do have a role in

treating psoriasis, especially in areas where a quick improvement is needed⁷ and where dithranol or salicylic acid is inappropriate, such as skin folds and on the hairline.

Potency and duration are the key factors in deciding which steroid to use. Hydrocortisone may be used on the face if necessary. Strong topical steroids should be reserved for use only when the psoriasis is disabling or unresponsive to other treatments.

As lesions improve, the amount of steroid applied should be reduced to prevent local side-effects. After three weeks, emollients should be substituted to prevent tachyphylaxis, before re-introducing the steroid. Psoriasis can quickly recur with steroid withdrawal, and tolerance can build up.

● Vitamin D3 analogues

These inhibit keratinocyte proliferation and modify T-lymphocyte function. Products are licensed for psoriasis vulgaris only and they are not recommended for use on children due to lack of clinical experience.

Calcipotriol was the first to be launched and has been welcomed as it offers a clean, easy to use cream effective in two-thirds of patients.

Usage should be restricted to not more than 100g of the 50mcg/g cream or ointment per week, applied twice daily. It should not be used on more than 40 per cent of the body surface due to the theoretical risk of vitamin D toxicity. In lotion form, calcipotriol may be used on the scalp.

Tacalcitol is the most recent vitamin D3 analogue. Maximum daily dose should not exceed 5g of the 4mcg/g ointment and only two eight-week courses are permitted in one year. It can be used on the face and need only be used once daily.

Other options

● **Ultraviolet light.** UVB is useful for chronic plaque psoriasis and guttate psoriasis; effectiveness can be increased with concurrent use of coal tar. UVA light can be enhanced with the use of psoralens (PUVA), taken orally or applied to the skin.

● **Vitamin A analogues or retinoids** These decrease plaque thickness and can be useful for pustular psoriasis. Use should be reserved for severe resistant or complicated psoriasis. Retinoids may also enhance the effect of PUVA treatment.

They are only available to hospitals or specified

community pharmacies.

● **Cyclosporin** This potent immunosuppressive agent has been licensed for oral therapy in psoriasis. Evidence suggests cyclosporin acts specifically on lymphocytes. Again, it should be used under the supervision of a specialist. Side-effects include reduced renal function and hypertension. Liver function should also be monitored.

● **Methotrexate.** This is an anti-metabolite and slows down cell division. It should be reserved for severe resistant psoriasis and be given only with suitable liver function, red blood cell and bone marrow tests. Normal levels should be established before therapy and monitored for some months afterwards.

Methotrexate is taken weekly and may induce anaemia and mouth ulcers. It is contraindicated in pregnancy, and contraception should be used for at least three months after stopping treatment.

● **Hydroxyurea** and **azathioprine** have been used in treating severe psoriasis due to their immuno-suppressive action, but their use is rare.

Patients can progress through a number of treatments, and it is important for them to have a regular contact in the community who they can ask for advice. The pharmacist can provide support and can also monitor patients' medication use, eg if steroid or vitamin D creams are being used excessively.

References:

- 1 The Merck Manual, 16th Edition, 1992.
- 2 Swanbeck G et al, *British Journal of Dermatology* 1995; **133**: 768-773.
- 3 *Nursing Times* Vol 91, 1995.
- 4 Patterson A, *Pulse* May 27, 1995
- 5 National Psoriasis Foundation
- 6 Kristensen J K et al, *British Journal of Dermatology* 1995; **133**:905-908.
- 7 GP Top 100, February 1, 1991

C&D is accredited by the CPP as a provider of distance learning material until December 31, 1997

Useful contacts:

- The Psoriasis Association, Milton House, 7 Milton Street, Northampton NN2 7JG. Tel: 01604 711129. Patient information may also be obtained from:
- Leo Laboratories (patient leaflets). Tel: 01844 347333.
- Dermal Laboratories (leaflets and audiotapes). Tel: 01462 458866.
- Quinoderm (leaflet). Tel: 0161 624 9307.

Falling down again

Drug treatment has once again been implicated as a risk factor for falls and injuries in elderly people. In Finland, falls account for 80 per cent of injuries in the elderly and injury is the fifth commonest cause of death in this population.

Epidemiologists have explored which factors increase the risk of falls in a rural community of 979 people aged over 70 who were living at home. Difficulties with walking, vision and muscle weakness were clear problems for most people, but drugs also contributed to the risk of injuries from falls.

Calcium channel blockers, anti-inflammatory drugs, cardiac glycosides and long-acting benzodiazepines were each significantly associated with falls leading to major (eg fracture) or minor (eg sprain) injury. Verapamil, diltiazem and nifedipine, in particular, were all separately implicated. Among women, drugs to improve the peripheral circulation and antidiabetic agents were also significantly associated with falls.

It is unclear from this study whether drugs are always the primary cause of falls or markers of physical difficulties which predispose to falling. For example, peripheral neuropathy and orthostatic hypotension associated with diabetes may be the underlying cause in elderly people taking



antidiabetic agents; and anti-inflammatory drugs may indicate mobility problems.

Nevertheless, drug-induced hypotension, dizziness and tiredness are likely to be important factors. The link between injurious falls and drugs used to treat peripheral vascular disease is of particular concern given the lack of evidence of efficacy for

many of these agents.

Drugs for the treatment of cardiovascular disease, joint disease and sleep disorders should therefore be used to flag an increased risk of injury in elderly people. In some cases, treatment may be ineffective and could probably be withdrawn without detriment. *Age and Aging* 1996;25:29-38

Nailing pulsed anti-fungal therapy

The treatment of fungal nail infections is usually prolonged: success depends on the deposition of fungicidal concentrations in the nail, which grows only slowly. Several months' treatment is therefore the norm.

Belgian dermatologists and manufacturer Janssen have now found an alternative dose regime which offers savings and possibly greater acceptability and safety. Instead of continuous daily administration, they evaluated pulsed therapy using a dose of 200mg twice daily for only one week in each month given over three or four months in 50 patients with proven fungal infections of the toenails.

Even with the three-month regime, the concentration of itraconazole in the nail increased from 67ng/g after one month to a peak of 471ng/g after six months; significant levels were still present in the distal ends of the nail at follow-up after one year. By that time, 84 and 88 per cent of patients were judged clinically cured after three and four months' treatment, with mycological cure rates of 64 and 72 per cent respectively.

The cost of pulsed treatment of onychomycosis over three months is half that of the current recommended dose and achieves an acceptable response rate.

Archives of Dermatology 1996;132:34-41

Compliance with cystic fibrosis treatment

It would be logical to expect that people with serious symptomatic disease would always adhere closely to their treatment regimes, but this appears not to be so.

Specialists from Leeds have investigated compliance among their patients with cystic fibrosis and found it surprisingly low. This, they say, has implications for our understanding of compliance.

Eighty of 91 patients surveyed provided information about their use of 12 daily medications (including antibiotics, vitamins, steroids, pancreatic enzyme supplements and insulin) and the

factors which they believed influenced their decisions to take them. Good compliance was defined as taking the prescribed dose at least nearly every day; moderate compliance, doing so on three to five days per week; and poor compliance, taking the dose on fewer than three days weekly or never.

Self-reported good compliance ranged from 100 per cent with insulin or glibenclamide to 40-50 per cent with dietary supplements and physiotherapy. Compliance with oral or inhaled steroids or bronchodilators was moderate in 20-27 per cent of respondents and poor in 11

per cent. Only two-thirds reported good compliance with nebulised antibiotics and 83 per cent did so with oral antibiotics.

The degree of compliance was generally better among patients who attended outpatient clinics more often but was not noticeably better in patients with greater understanding of cystic fibrosis.

The commonest reasons cited for omitting doses were forgetfulness; the effort or time required to take nebulised or inhaled drugs; and perceived lack of efficacy. Some felt embarrassed about taking pancreatic enzyme supplements in public

(because of the large number of capsules needed) and others said the drugs tasted unpleasant or made them feel worse.

Intensive treatment of a serious chronic condition is a burden so it is not surprising that people want some escape – even when there is a strong link between symptom relief and treatment.

The authors of this study suggest that poor compliance, far from being unusual, is a universal aspect of normal behaviour and that it should be taken into account when planning treatment regimes.

Thorax 1996;51:29-33

40 YEARS OF PARACETAMOL

'Paracetamol looks set to be as successful a home remedy in the next forty years as it has proved over the last'

Effective and safe

Primarily a prescription medicine at launch paracetamol was soon made available OTC, and has now grown to be the most widely accepted antipyretic and analgesic in the UK, estimated to be used by over 30 million people every year. There are over 2½ billion tablets sold OTC in a year, and over half a billion tablets supplied on prescription each year, with 80% of all paracetamol tablets consumed being supplied via the pharmacy. This remarkable success story is based on the efficacy of paracetamol as a mild analgesic and its proven effectiveness as one of the best antipyretics available, combined with an impressive safety record. At recommended doses there are seldom any side-effects, and few interactions with other medicines.

Broad patient range

Practically everyone can take paracetamol, from the very young to the very old. Paracetamol liquid is recommended even for babies two or three months of age to reduce the fever that may arise from immunisation. At the other end of the age scale, paracetamol is cleared normally in the elderly with no reduction of the standard recommended dosage necessary.

Dosage

The recommended single dose for adults is usually two

500mg tablets. This can be repeated after four hours, up to a maximum of eight tablets in a 24 hour period. The recommended single dose for children is clearly printed on the label and should not be given more than four times in twenty four hours.

There is a relatively short dose response curve with little benefit to be gained from increasing the dosage above recommended levels, and there is therefore no justification for any patients to exceed the recommended dosage. If paracetamol is not working at the standard dosage, patients should be referred to their doctor.

Overdose

Paracetamol, like many other medicines, has been used by people intending to overdose. Overdoses of 15 grams (30 standard tablets) and over may cause serious liver damage if not treated with intravenous acetylcysteine within, preferably, 12 hours, or certainly within 24 hours. It is important that medical attention at a hospital is sought following an overdose even in the absence of symptoms, particularly as there are likely to be few

symptoms in the first 24 hours. Contrary to popular belief paracetamol overdose does not cause drowsiness, sleep, or loss of consciousness. Antidote treatment is extremely effective but is necessary in only a very small proportion of overdose cases. Fortunately well over 99% of people who present at hospital with claimed paracetamol overdose recover with no long term ill effects.

Methionine combinations

Preparations combining paracetamol with methionine to render overdosage less harmful, known as co-methiamol, may be useful in circumstances where someone is known to be at risk of taking an overdose. However, recent research

indicates that they are likely to be avoided by the majority of those contemplating taking an overdose.

Combinations with methionine are no more effective analgesics than paracetamol alone and may be less safe at recommended dosage in long term use. Methionine carries risks of side-effects that do not occur with paracetamol alone.

The future

The advantages of paracetamol are such that it is increasingly the drug of choice in formulating new combinations and preparations both for mild to moderate analgesia and for cold and flu symptom relief.

Its broad patient range, lack of clinically important interactions, and remarkably low incidence of side-effects ensure the place of paracetamol among the top selling medicines.

Paracetamol looks set to be as successful a home remedy in the next forty years as it has proved over the last.

CUSTOMER ADVICE LEAFLETS

Leaflets containing information for customers enquiring about paracetamol can be obtained free from:

Paracetamol Information Centre,
Suite 413 Butlers Wharf,
Curlew Street,
London SE1 2ND.

Do oral steroids lead to infection?

Corticosteroids can increase the risk of infection because they are immunosuppressant. Chest infections can be a problem for asthmatics, yet many must occasionally use oral steroids to control acute exacerbations, but what is the overall risk?

US paediatricians followed up 78 children (mean age 5.4 years) who attended hospital with acute exacerbations of

moderately severe asthma on two or more occasions in the preceding year. Only 40 per cent were taking prophylactic medication. On average, each child took ten doses of prednisone 2mg/kg but 13 received no treatment.

There were 222 symptomatic episodes in 62 children and 94 confirmed infections in 50 children over the following year. The commonest infections were

otitis media (40), ringworm (16), skin infections (14) and chickenpox (11). All these are common among all children and there was no correlation with the dose of steroid or the number of doses taken. Nor were they less frequent in steroid-free children.

The authors advise caution in using steroids in children. *Archives of Pediatric and Adolescent Medicine* 1996; 150:58-63

Acne treatment and resistant bacteria

Antibiotics are the most commonly prescribed therapy for mild to moderate acne and one of the most popular agents is erythromycin. However, widespread topical use has resulted in resistance.

One way to reduce the risk that resistant strains will emerge during treatment is to use two antibacterial agents with complementary mechanisms of action. *In vitro* data suggest benzoyl peroxide and erythromycin have synergistic or additive activity against propionibacteria and a topical formulation of erythromycin and benzoyl peroxide has now been shown to prevent the emergence of resistant bacteria.

Compared with topical erythromycin 3 per cent alone, twice daily use of a gel containing erythromycin and benzoyl peroxide achieved a greater reduction in skin propionibacteria and reduced the persistence of erythromycin-resistant strains. The combination also reduced the population of *Staphylococci* and the overgrowth of resistant strains. This was maintained for the 12 weeks of the study, though the effects of both preparations diminished and several patients in each group acquired new resistant strains after 12 weeks.

Combined therapy offers an alternative when monotherapy is unsuccessful, but the emergence of resistance indicates poor compliance when symptoms improve may be a factor in treatment failure.

British Journal of Dermatology 1996;134:107-13

Research Digest is a regular series written by drug information specialist Steve Chaplin MRPharmS looking at current developments in medicine

Mortality and long-term HRT

Evidence is accumulating about the effects of hormone replacement therapy on the risk of death in postmenopausal women.

Although the balance indicates a favourable effect, some studies show no benefit. Many are based on HRT use over five to ten years but a US study gives data on use for an average 17 years.

All-cause mortality and mortality due to specific conditions were compared in 232 women who began taking conjugated oestrogens within three years of the menopause and 222 matched controls.

The average dose of oestrogen was initially

0.9mg/day but this was reduced to 0.5mg/day by the mid-80s. Only 5.6 per cent of women had ever taken a progestogen. Follow-up extended to an average of 27 years after the menopause in both groups, when a quarter of users were still taking HRT.

After adjusting for risk factors, such as hypertension, smoking and serum cholesterol, the risk of death from any cause in HRT users was almost halved. Longer duration of HRT use was associated with a lower risk, declining from a relative risk (RR) of 0.69 after less than 15 years to 0.48 after longer use. The risk of death was least in

women taking the lowest dose of HRT, ranging from 0.10 at 0.3mg/day to 0.99 at 1.23mg/day. Most of the reduction in risk was due to a lower risk of cardiovascular disease (RR = 0.27) and coronary heart disease (RR = 0.40). Overall, the risk of death from cancer was similar in the two groups but there was a trend for HRT users to be at slightly increased risk of breast cancer (RR = 1.89) and at lower risk of lung cancer (RR = 0.22).

This study adds support to the case that HRT reduces post-menopausal mortality. *Obstetrics and Gynaecology* 1996;87:876-12

Fluoroquinolones safe for use in children

Fluoroquinolone antibacterial agents, such as ciprofloxacin, are not recommended for children unless the benefit outweighs the risk of cartilage damage.

Oxford specialists have monitored the level of risk in Vietnamese children treated with fluoroquinolones during an outbreak of multi-drug-resistant typhoid fever.

In a prospective study, 326

children aged 1-14 years were treated with ciprofloxacin for seven days or ofloxacin for three to five days and followed up for two years.

Treatment was well tolerated and there were no acute effects on joints. There was no evidence of bone or joint symptoms or tendon rupture at follow-up after one or two years. Children treated with ciprofloxacin were found

to have grown more quickly than ofloxacin-treated children and controls after one year, but there were no differences after two years.

The authors point out that there is no alternative oral treatment for multi-drug-resistant typhoid, which can be cured with three days' ofloxacin treatment. *Archives of Disease in Childhood* 1996;74:44-6

PHARMACY update: distance learning for pharmacists

Pharmacists using **Pharmacy Update** as part of their continuing education requirement are reminded that testing of comprehension and knowledge retention is an essential part of the learning process.

With the support of Johnson & Johnson MSD, C&D readers can self-test their progress by using the multiple choice question

(MCQ) paper to be inserted in the April 13 issue, which will cover this week's module, together with those in the March 2 issue.

So far, ten accredited modules have appeared in this series:

- Communication skills (01)
- Rheumatoid arthritis (02)
- ACE inhibitors (03)
- MCQ for modules 01-03 (70)

- The endocrine system (04)
- Sleep disorders (05)
- Pituitary problems (06)
- Croup (07)
- MCQ for modules 04-07 (71)
- Hormonal contraception (08)
- Schizophrenia (09)
- Psoriasis (10).

A faxback service for these modules and associated MCQs operates on 0891 444791

(premium rates apply). A telephone marking service offers independent verification of results - details of how to register are given on the monthly MCQ papers.

C&D in association with

Johnson & Johnson MSD
Consumer Pharmaceuticals



This tenth module is concerned with *babycare, including feeding and skincare.*

In this month's Pharmacist's Briefing reference icons are used as follows:



Information



Refer to BNF



Treatment



Refer to pharmacist



Refer to doctor or specialist

A similar set of icons is used in the assistants' module.

BREASTFEEDING



The key message is that breast is best. Assistants should never try to discourage a woman from breast-feeding or promote infant formula as being better than breast milk.

Babies can live on breast milk alone for the first four to six months, and breast-feeding should continue for at least a year if possible.



Assistants are asked to refer to the pharmacist:
■ **Mothers who think their baby is failing**

to thrive. A thriving baby is alert, has bright eyes and a healthy skin colour, gains weight properly and wets the nappy frequently. A baby who is not getting enough to eat will have poor weight gain and will be quiet and unresponsive. Babies should be fed on demand and not at set times. Frequent suckling stimulates the secretion of prolactin and oxytocin which increase milk production. The baby should empty one breast first then transfer to the other, as the more satisfying, richer milk increases towards the end. The baby should not be hurried. Mothers who think they are not producing enough milk should resist the temptation to supplement breast-feeding with an infant formula; this can reduce her own supply and the baby may grow to prefer the bottle, which requires less effort. She should also ensure her own diet contains adequate protein, calcium and fluids, and try to rest

and relax as much as possible. The mother might just need reassurance, but if she is still concerned, the health visitor, midwife or GP will be able to check her feeding technique and that the baby is gaining weight and developing at the right pace.

■ **Mothers having problems with breast-feeding.** Those who want to convert to bottle-feeding. Again, the health visitor or midwife is best placed to advise on feeding technique. Pharmacists can reinforce the positive aspects of breast-feeding, while trying not to make the mother feel guilty if she decides against it.



■ **Breast-feeding women who are taking medicines.**

Refer to BNF for list of medicines which are excreted in breast milk. The most important ones to avoid include anti-cancer drugs, lithium, phenindione, thiouracil, ergot, sulphonamides and tetracyclines. Large amounts of alcohol may affect the baby and decrease milk production. Nicotine and caffeine pass into breast milk.

■ **Other feeding problems.** A blocked nose due to a cold can interfere with feeding. Saline nose drops can help to clear the nose before a feed, chest rubs may ease congestion (check age). If the problem persists, or if a baby stops feeding because it is unexpectedly drowsy or seems unwell, refer to GP.

■ **If the nipples are too sore to breast feed.** The baby may not be in the correct position when feeding, with the head supported. The midwife or

health visitor will be able to ensure the baby is sucking correctly. OTC nipple creams and ointments can prevent cracking. The mother could also try expressing milk into a sterile bottle for a couple of days.

■ **Swollen and engorged breasts.** The breasts may be over-full and painful a couple of days after the birth. The mother could try feeding more often or expressing some milk by hand. A blocked duct, which appears as a tender red lump, can be very painful. Massage while feeding may help and the breast can be emptied by frequent feeding or by expressing the milk. Refer to midwife, health visitor or GP if any professional concern. Hot, tender breasts with feverishness could indicate mastitis; refer to GP if there is no improvement in about eight hours.

BOTTLE-FEEDING



Both whey-dominant and casein-dominant milks can be given from birth, but the former are better to

start with as they are more easily digested and the protein balance is more like breast milk. Casein dominant milks are recommended for hungrier babies.

Cows' milk is not suitable as the main drink until the baby is at least a year old, although it can be used to mix with food during weaning. It is too high in protein and sodium for babies and does not contain enough iron or vitamins A, C and D. Follow-on milks can be given between six months and two years old.



Referred:

- **Parents who want to change milks.** If the baby seems hungry, changing

from a whey-based to a casein-based milk is better than introducing solids too soon. The baby may be thirsty, so boiled then cooled water should be offered between feeds. If the mother is concerned that the baby is not thriving, refer to midwife, health visitor or GP. Pre-term and low birthweight formulas should be given only on medical advice.

- **Babies with symptoms of food intolerance.** Babies may be intolerant to cows' milk protein or lactose. The reaction may appear soon after birth or after an attack of gastro-enteritis. Symptoms include diarrhoea, vomiting, colic, wheezing, skin rash and poor weight gain.



As these symptoms may have other causes, refer to a GP for diagnosis. Soya formula should only be started on medical advice.

Vitamins



Vitamin A and D supplements should be given to:

- Breast-fed babies under six months whose mothers were poorly nourished in pregnancy.
- Breast-fed babies over six months.
- Bottle-fed babies drinking less than 500ml (1 pint) of infant formula or follow-on milk a day.
- Children between one to five years, unless the diet provides enough of these vitamins and there is a moderate exposure to sunlight.

Foods and drinks rich in vitamin C should be encouraged in the weaning diet.

WEANING



The Government's Committee on Medical Aspects of Food Policy (COMA) recommends that weaning should

start between four to six months. Before this age, kidney and gut function may not be sufficiently developed. Under three months the baby is unlikely to be able to sit up and swallow properly or move foods around the mouth. If delayed beyond six months, key stages in development will be missed and the baby may have difficulty learning to chew. Refer to the health visitor if there is any concern about whether the baby is ready. Signs include fist sucking and more frequent demands to be fed.

Baby drinks can be given from about four months. Salt must not be added to foods, as the undeveloped kidneys cannot cope, and adding sugar can encourage development of a sweet tooth

which may eventually lead to tooth decay. Gluten-containing foods are best avoided before six months, particularly in families with a history of coeliac disease. Eggs should always be well cooked and the whites avoided before eight months. Low fat, high fibre diets are not suitable for babies.



Referred:

- **Babies who go off their food.** When weaning, it is best to let a baby try one

new food at a time, allowing a couple of days to get used to it before introducing another. If a baby refuses food occasionally and seems healthy, there should be no need to worry so long as he is drinking milk and extra fluids such as water. If there are other symptoms such as fever and listlessness, refer to GP.

- **Parents who want advice on vegetarian or vegan diets.** Babies on vegetarian diets should eat foods from the following groups: cereals and grains, including pasta, bread and rice; fruit and vegetables; dairy products; pulses, nuts (finely ground), seeds, eggs and soya products. Including foods with little or no fibre helps ensure that the baby has eaten enough calories before he feels full. Parents wishing to follow a vegan diet should consult a GP or dietician.
- **Parents who wish to start weaning before three months.** Refer to the health visitor if the mother is already giving a casein-based milk and offering boiled water if the baby could be thirsty.

COLIC



Crying bouts which occur between the age of three weeks and three months, usually in the evening, may be due to wind trapped in the intestines, although there are many other theories. The baby draws his legs up, goes red in the face and may have a swollen abdomen.



Treatment:

Short-term use of gripe mixtures, or longer more regular use of colic drops containing dimethicone. If the baby is breast-fed, omitting dairy products from the mother's diet may help but it is important she replaces the missing calcium.



Referred:

- **Crying accompanied by vomiting, a pale skin or rise in temperature to**

38°C or more. Screaming which could indicate severe pain. Refer to GP.

- **Babies experiencing colic symptoms for the first time.** If the baby seems healthy, recommend colic drops and refer to GP or health visitor if

there is no response after five to six days.

- **If symptoms get worse or persist after four months.** Refer.
- **Persistent crying for no apparent reason.** Babies cry to communicate that they are too hot, too cold, hungry, wet, lonely, teething or have colic. If all these reasons have been excluded and the baby is otherwise healthy, the parents should be referred to the health visitor or a support organisation such as Cry-sis (0171 404 5011) or Parentline (01702 559900).

VOMITING



Bringing back small amounts of the feed (possetting) is normal.



Referred:

- **Severe or persistent possetting.** This should be referred to a GP or health

visitor if the baby seems unhappy and fails to put on weight. They might recommend thickening powders for the feed.

- **Regular vomiting for more than six hours. Diarrhoea for more than 24 hours.**



Refer to GP, particularly if there are signs of dehydration (dry lips, tongue and mouth, dark yellow urine, infrequent urination, a sunken fontanelle and weak floppy body). Breast-fed babies should continue feeding if possible. Bottle-fed babies under six months should be given electrolyte solutions instead of milk for 24 hours.

SKINCARE

1. Cradle cap

The scales can be softened with olive oil, baby oil or emulsifying ointment and washed off with baby shampoo. Cradle cap preparations containing salicylic acid are also recommended.



Referred:

- **If the condition does not respond to OTC treatments or becomes infected.**

Refer to GP.

- **If the rash spreads to the face.** This could indicate seborrhoeic dermatitis which can be confused with atopic eczema. The former causes little discomfort and usually starts in the first weeks of life, clearing by the time the baby is a year old. It may also spread to the nappy area. Refer.

2. Nappy rash



Referred:

- **If the rash does not respond to OTC treatments.**

Check that the parent has followed a careful nappy changing routine and also

tried leaving off the nappy for long periods. If these measures and standard OTC treatments fail, refer to GP after a week.

- **If the rash is weeping or bleeding. If there is pus, yellow crusts or white patches, or if there are white patches in the mouth.** Weeping skin, pus or yellow crusts suggest a bacterial infection, so refer to GP. Candida infection appears as whitish patches with papules bordering the main rash and down the inside of the thighs. It can be treated with an anti-fungal cream such as miconazole or clotrimazole, for up to ten days after the rash has cleared. White patches in the mouth can indicate oral thrush which in turn can re-infect the nappy area, so should be treated with miconazole oral gel until two days after the symptoms have disappeared. If the mother is breast-feeding she should also apply the gel to her nipples. Teats and bottles must be thoroughly sterilised if bottle-feeding. Refer to GP if there is no improvement within five days.

3. Other rashes



Assistants are advised to refer to the pharmacist if they are not sure what the rash is, if it is severe or the area round the eyes and mouth is affected, or if it could be eczema. These topics were covered in Skin Disorders, Module 9.

CHILDHOOD INFECTIOUS DISEASES



Assistants are advised to refer to the pharmacist anyone who thinks their child is suffering from chicken pox, measles, rubella, mumps or whooping cough.



It is wise to refer to the GP for a diagnosis (immediately in the case of whooping cough). In particular refer:

- Children who develop earache or who get worse with measles (possible pneumonia or encephalitis).
- Stiff neck or headache with German measles (possibility of encephalitis).
- Severe headache and stiff neck after measles (possibility of meningitis or encephalitis), or abdominal pain in girls, pain in the testes in boys.

Immunisation



Vaccinations against diphtheria, pertussis, tetanus, haemophilus influenzae B and polio are given in the first year, measles, mumps and rubella in the second year (see BNF). Babies who are feverish after injection may be given liquid paracetamol; refer if pyrexia persists after two doses.

A woman in her 20s hands you this prescription. She complains that she had enough trouble with thrush when she was taking the Pill and that she thought she'd seen the last of it. Her spots aren't getting any better either and she's been taking the antibiotics for a month now

Miconazole pessaries
tbd (14)
Erythromycin 500mg
tbd (56)



Questions

1 Can you suggest two possible causes – one treatment-related, one not – of vaginal candidiasis in this case?

2 Is it time to change the antibiotic if it's not improving the acne? What treatment options are available?

3 What warning would you give about the pessaries?

4 What alternatives to miconazole are available for the treatment of vaginal candidiasis?

Answers

1 Vaginal candidiasis may be associated with the use of broad spectrum antibiotics, such as erythromycin, which alter the vaginal environment by selectively eradicating commensal bacteria. Alternatively, since she has a history of candidiasis, she may have a chronic infection or be being infected repeatedly by her partner.

2 The lack of improvement in her acne is not a reason to change

the antibiotic: treatment takes three months to achieve a significant benefit and the drug should be changed if there is no improvement by then. An oral tetracycline would be suitable. If further episodes of candidiasis occur and erythromycin is believed to be the cause, alternative treatment should be considered. Options include a topical antibiotic, a retinoid or hormonal treatment depending on acne severity; she should already be using cleaning agents.

3 Miconazole (and other triazole) pessaries damage the latex of condoms and diaphragms, and, since she is not taking an oral contraceptive, these are the most likely forms of contraception. Check that contraception has been discussed with the GP.

4 Recurrent candidiasis should be treated with oral fluconazole or itraconazole. Most other topical imidazoles are either incompatible with latex or their effects are unknown; one exception is Gyno-Pevaryl cream. Nystatin gel and pessaries also cause no damage. Her partner should also receive treatment.



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Society to challenge P to GSL 'convenience' criteria

The Royal Pharmaceutical Society is to challenge the concept of 'convenience to the purchaser' as a criterion for deciding if a product might be suitable for general sale.

The Medicines Control Agency's draft procedures for P to GSL changes set out two criteria for general sale. One was that GSL may be appropriate for medicines which could "with reasonable safety be sold or supplied otherwise than by or under the supervision of a pharmacist". The other was "where the hazard to health, the risk of misuse or the need to take special precaution in handling is small and where wider sale would be a convenience to the purchaser".

At the Society's Council meeting last week, the Law and Ethics Policy Committee had no objection to the first criterion as it merely referred to the provisions of Section 51 of the Medicines Act. The Committee felt strongly that the second criterion was not a valid argument, given the accessibility and long opening hours of pharmacies.

A safe track record of sale through pharmacies should not be taken as a guarantee of safety through general channels, where there would be no professional advice and intervention.

All these points will be made in a reply to the MCA. Council also agreed to seek a meeting with the health minister, Gerald Malone, to promote the Society's policy.

● **Continuing education** The Society is considering asking pharmacists to declare, voluntarily, how much continuing education they do each year. The information could be returned with the retention fee forms.

Peter Curphey asked about progress in implementing Council's decision to verify pharmacists' compliance with the Code of Ethics' expectation that they would do at least 30 hours continuing education a year. The secretary and registrar, John Ferguson, replied that this issue was in the education division's one-year plan, but no substantial progress could be made until the division was fully staffed.

● **Ethnicity** Council decided that the Society should not collect data on pharmacists' ethnic origins, as had been suggested by the Commission for Racial Equality. The Law and Ethics Policy Committee could see no useful purpose in this, as there was no possibility of the Society discriminating in the registration of pharmacists or in the exercise of professional disciplinary responsibilities.

● **Tribunal** The proposed new Byelaw establishing a pharmacy standards tribunal is to be submitted to the Privy Council for approval. The proposed rules of procedure originally stated that a pharmacist could be represented by a lawyer or friend who was a member of the Society. The words 'is a member' will be removed to allow for trade union, staff association or other appropriate representation.

● **OTC medicines campaign** The Society is to seek a meeting with the Proprietary Association of Great Britain to consider an information campaign encouraging the public to ask questions of pharmacists before buying medicines. There has been a useful meeting with the Consumers' Association, and the National Consumer Council has now asked for a meeting to discuss 'Pharmacy in a New Age'.

● **Marketing pharmacy** Council approved a resource pack on marketing community pharmacy to health authorities. The pack will be distributed to Branch secretaries, LPC secretaries, area chemist contractors' committee secretaries, heads of pharmacy schools, pharmaceutical advisers and IIA pharmacists. Copies will be available, price £5, from the Society's practice division.

NI figures ...

Northern Ireland pharmacists and appliance suppliers dispensed 1,673,409 items last December at a gross cost of £16,207,074.54 and a net ingredient cost per prescription of £8,108.7.

... and Scots

Some 4,462,997 prescriptions were dispensed by Scottish pharmacists and appliance contractors in December, at a gross cost of £41,491,471 and a net ingredient cost of £8,621.9 for pharmacists and £8,758.1 for appliance contractors.

NPA heart leaflet issued

The National Pharmaceutical Association has issued 'Coronary heart disease and the community pharmacist' which outlines areas highlighted in the Health of the Nation campaign.

Book flu vaccine now

GPs are being advised to book next winter's flu vaccine supplies as soon as possible for delivery in September/October. The World Health Organisation has confirmed that the 1996/97 flu strains will be: A/Wuhan/359/95; A/Singapore/6/86 and B/Beijing/184/93.

Homoeopathic fees

Schedule 2 of the principal Regulations in the Medicines (Homoeopathic Medicinal Products for Human Use) Amendment Regulations 1996 (SI No 482, HMSO, £1.10) have been substituted, with effect from April 1. The substitution outlines the fees for applications for the grant of certificates of registration.

New Age Unichem

Unichem is to make seven submissions to the Society's 'Pharmacy in a New Age' initiative: one from its executive team; one from the Moss Chemists division; and one each from the five regional committees.

UCA's May conference

The Ulster Chemists' Association is running a conference and trade exhibition on May 12 at the Sleeve Donard Hotel, Newcastle, under the title 'Pharmacy retail: the year 2000'.

LPC election reminder

LPC election papers must be returned to the Electoral Ballot Reform Services by March 22. The deadline has been extended to March 29 for Southampton and South West Hampshire.

PAGB to update healthcare study

The Proprietary Association of Great Britain is looking into how attitudes to treating minor ailments and chronic illness management have changed in the past ten years.

The 'Everyday Health Care Study' will compare findings with a similar survey in 1987. It will also look at new issues which have arisen, such as POM to P changes.

The one-year survey of 2,000 subjects will begin in May.

Alison Williamson of the PAGB says final results will be published in June, 1997, but the PAGB hopes to publish quarterly top-line results throughout the year.

● The PAGB is launching its first-ever parliamentary lobby. Roger Sims MP will sponsor a PAGB reception at the House of Commons on March 28.

ALPS finalises training seminar details

The Association for Local Pharmaceutical Committee Secretaries has finalised its training seminar programme.

The two-day seminar, at Loughborough University on April 27-28, will cover: time management; office organisation and secretarial responsibilities; Microsoft/

Windows 95, sponsored by 3M Healthcare; and handling LPC accounts, presented by the Pharmaceutical Services Negotiating Committee's financial executive, Godfrey Horridge.

In addition, a panel of LPC secretaries will offer help and advice in a question and answer session.

Which? denies pharmacist bias

Pharmacists are not being 'singled out' for attention by *Which?*, according to the Consumers' Association.

In response to a letter from London pharmacist, Ashwin Tanna, expressing his concern over the latest *Which?* pharmacy survey (*C&D* January 6, p5), the CA defends its policy.

"Pharmacy supervision is a legitimate area of consumer

interest ... this is particularly true in view of the increased number of medicines available now over the counter," writes Lesley Hills of the CA's membership services.

The last survey attracted criticism over its unlikely situations, but Ms Hills says: "In each scenario there was at least one pharmacist who got it right. This showed our scenarios were entirely realistic."

Sufferers choose it for speed
 You recommend it for peace of mind
 Brilliant new deal for you in 1996

With Clarityn Allergy, hayfever sufferers get what they want; relief from symptoms within minutes¹ – nothing works faster! What's more they'll stay alert throughout the day² and be sure of a full 24 hours relief³ from a single tablet.

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Product Information

Clarityn Allergy: Clarityn Allergy tablets contain 10mg loratadine. **Indications:** For the relief of symptoms associated with hayfever, allergic rhinitis and urticaria. **Dosage:** Adults and children aged 12 and over: One tablet once daily. **Contra-indications, precautions:** Hypersensitivity. Pregnancy and lactation. **Side-effects:** Rarely, fatigue, nausea and headache. **Pack size:** Cartons of 7 tablets. **Retail price:** £3.95. **Legal category:** [P]. **Product licence number:** 0201/0175. **Product licence holder:** Schering-Plough Ltd., Welwyn Garden City AL7 1TW. **Date of last revision:** August 1994.

Clariteyes: Clariteyes Eye Drops contain sodium cromoglycate Ph.Eur. 2% w/v. **Indications:** For the treatment of acute seasonal (allergic) conjunctivitis including hayfever. **Dosage:** Adults, children and the elderly: One or two drops into each affected eye up to four times daily. **Contra-indications, precautions:** Hypersensitivity. **Side-effects:** Transient blurring of vision, burning, stinging may occur. **Pack size:** 10ml. **Retail price:** £3.95. **Legal category:** [P]. **Product licence number:** 0201/0191. **Product licence holder:** Schering-Plough Ltd., Welwyn Garden City AL7 1TW. **Manufacturer:** Waverley Pharmaceutical Ltd., Runcorn, Cheshire WA7 1QE. **Date of preparation:** January 1994. **Prices correct at the time of going to press.**

References: 1. Soto Roman L., *Today's Ther. Trends*, 1988, 6: 19-27. 2. Belts T. *et al.*, *Proc. XIII Int. Congr. Allergol. and Clin. Immunol.*, Montreux 1988, 74-79. 3. Banov C., *J. Int. Med. Res.*, 1989, 17: 150-156. 4. Hey J.A. *et al.*, *J. All. Clin. Immunol.*, January 1994. 5. Afrime M.J. *et al.*, *J. All. Clin. Immunol.*, 1993, 91(1): 259. 6. Data on file, Schering-Plough. 7. Data on file, Janssen Research Foundation, February 1993. 8. Moser L., Plumm H., Bueckman M. *Eur. Acad. of Allergol. and Clin. Immunol.*, Budapest, May 1986, Abstract.



SCHERING-PLOUGH CONSUMER HEALTH
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Positive contribution

Who profits from interventions? The Department of Health: yes, through reduced prescribing costs. The patient: yes, with improved patient care. The pharmacist: no, because of increased workload for a reduced income.

A survey conducted in one pharmacy over 30 days in 1995 identified interventions that reduce the potential NHS payments for that pharmacy.

There is a substantial saving for the family health

reference to the pharmacist.

The examples shown are just a small selection from the many interventions made in community pharmacy. I post about 100 prescriptions back to surgeries each month for minor changes that would not be accepted by the PPA without the initials of a doctor.

We would expect 'computer produced' prescriptions to have reduced problems. Instead the opposite is true.

I would like to extend this survey to cover all interventions, just to prove that

By determining the average weight of annual returns from each pharmacy, and then comparing the weight and value of returns within a postal code district with that made by a similar number of 'average' pharmacies, a league table of postal code districts with above-average returns can be established.

These league tables could be used by health authorities to put pressure on GPs to limit prescribing to 28 days, and to consider the need for repeat prescribing reviews.

More impact is made if postal code districts are compared by the value of drugs returned to pharmacies rather than by weight.

Although the value of drugs returned will vary from pharmacy to pharmacy, if a figure can be found that is acceptable to the health authority, then a basis for comparison can be established.

I have used a figure of £205 per kilo, being the average value determined by DOOP services in an unpublished work (they weighed the top 30 prescribed drugs in various combinations). Assuming all loose tablets and capsules are emptied into a bin, while all packaged drugs are left in foil, the cost varies between £178,000 and £232,000 per

metric ton. Comparatively, if all drugs were left in the containers, the latter would account for 35 per cent of the quoted value.

Using this value in Bradford, over four tons of unwanted medicines were returned to pharmacies in 1995, with an estimated value of £878,275. The value of returned drugs for each pharmacy varied between £29,520 and £820, with an average of £8,387.

I have compared the weight of returns with the number of residential and nursing homes a pharmacy services, the number of beds in the homes, the average number of monthly scripts dispensed per pharmacy in 1995 and the GP list size for all areas.

There appears to be no conclusive evidence that any of the above influence the quantity of returned medicines to a pharmacy. This has led to the conclusion, in a report to Bradford Health, that the excessive quantities of unwanted medicines must be as a result of over-prescribing, and to recommend that prescribing be encouraged to be limited to 28 days.

D V Oxley
Community pharmacy
development office, Bradford
Health

Savings made for NHS over 30 days by type of intervention

Date	Type	Drug/Device	Qty	Saving
9/10/95	C	Finasterine 5mg	180	£160.07
	C	Proscar 5mg	90	£80.03
	A	Serc 8mg	100	£8.37
	A	Nifedipine caps 10mg	336	£23.05
10/10/95	A	Isosorbide mono 20mg	168	£8.03
	D	Pulmicort refill	1	£2.00
	D	Pulmicort refill	1	£2.00
	D	Diskhaler refills	1	£0.57
20/10/95	D	Pulmicort refill	1	£2.00
24/10/95	D	Diskhaler refills	1	£0.57
27/10/95	B	Quinine not Quinidine	100	£1.66
1/11/95	B	Ipratropium nebs	1,520	£547.20
	D	Ranitidine	28	£13.01
	B	Maxijul 1,120 140g sach	1,112	£3,124.72
	D	Volstarol 100mg	28	£12.72
Total				£3,983.43

services authority, but there is a hidden cost to the pharmacy. We are improving patient care and increasing our workload, but reducing the number of items for which we are paid.

There are four reasons for intervention (see table above):
A patient prescribed a new drug without cancelling the old
B computer 'errors'
C both generic and branded names of a drug ordered on the same prescription
D patient volunteering that they do not need a specific item.

● Maxijul 1,120 sachets should be Maxijul 1,120g in 140g sachets, ie eight sachets.
● The ipratropium nebs 80 OPs were ordered instead of 80 nebs or four OPs.

As well as actually saving the cost of the drugs, there is the additional saving of dispensing fees and container allowance when an item is deleted. I have spoken to the computer operators at the surgeries who typed the prescriptions and have been assured that these have been ordered correctly!

Computer errors cause the most anxiety because they tend to repeat each month. I have seen the two highest value items on three occasions. It is possible that payment would be authorised by the Prescription Pricing Authority without further

pharmacists make a positive contribution to primary care, but time spent on direct patient care is too precious to be eroded by the paperwork.

Brian Hopkins
Luton

A weighty matter

You might like to hear how Bradford has demonstrated that the collection of unwanted medicines is not just a free service, but a valuable resource to monitor possible over-prescribing.

DUMP campaigns in the past have produced flawed information by making the assumption that the returns to selected pharmacies in a very short space of time can be used to extrapolate the value of annual waste for a city or district. Most areas have valued the waste from one or more pharmacies, made assumptions, and then concluded that any figure derived can be applied to other areas. Very few studies have applied values to weights of returns to produce a figure such as £/kg.

Although comparing quarterly weight returns of unwanted medicines will identify pharmacies with consistently high returns, more impact can be made by putting a value on the drug waste and then comparing postal code districts.

MMC INVITES EVIDENCE INTO THE PROPOSED ACQUISITION OF LLOYDS CHEMISTS PLC BY UNICHEM PLC

The Secretary of State for Trade and Industry has referred the proposed acquisition of Lloyds Chemists plc by Unichem plc to the Monopolies and Mergers Commission.

The Commission will be considering the effects of the proposed merger on the wholesale and retail pharmaceutical markets in the UK.

The Commission would welcome any views from interested parties in writing, by 29 March if possible. Anyone wishing to submit evidence, or to obtain a copy of the full terms of reference, should write to: The Reference Secretary (Unichem/Lloyds), Monopolies and Mergers Commission, New Court, 48 Carey Street, London, WC2A 2JT, quoting ref: C&D06.

FOCUSING ON THE PUBLIC INTEREST.

Managing change

The Institute of Pharmacy Management's spring meeting, held last weekend in Jersey, highlighted the need to rethink business strategy in the light of declining NHS margins and increasing competition from grocery. Speakers also pointed up the necessity for motivation and reward schemes for staff

The value of training staff and the need for incentive and motivation schemes were highlighted by pharmaceutical consultant Gerry Green. Mr Green was discussing the preliminary results of a survey into pharmacists' and pharmacy staff's salaries at the spring meeting of the Institute of Pharmacy Management.

Initial results indicated that employers did not pay pharmacists for additional activities, such as continuing education or working with nursing homes. Many employers said these activities were part of the conditions of employment. The survey



Consultant Gerry Green

Tidy up your taxes

Get your taxes in order before self-assessment arrived was the advice from David Hopkins, a partner at Price Waterhouse.

Self-assessment was set to put the tax liability onus on the individual, rather than the Inland Revenue. The Revenue had "been pretty sneaky" about introducing self-assessment, said Mr Hopkins: it first said that self-assessment would simplify personal tax issues. This was not the case; it would make things easier for the Revenue, not for the individual.

Self-assessment would be a very trusting system, with individuals calculating their own returns, but the Revenue would be carrying out 10,000 random audits in the first year and would

found a wide range of hourly rates for pay, ranging from less than \$10 to over \$20, but very few companies had any motivation schemes for pharmacists.

This state of affairs was similar for other pharmacy staff. While larger multiples (Lloyds and Boots did not take part in the survey) and supermarkets rewarded staff for extra time and effort, the rest of pharmacy spent very little or nothing on rewarding staff.

Pharmacists may also face problems in the future if a change of Government brought in a ruling about a minimum wage. Present estimates suggested a minimum wage of \$4 an hour was not unlikely, while current NJIC rates were \$3.09. The average pay for dispensers was \$3.39. Hospital rates for technicians were much higher, starting at \$4.75 per hour.

Wages were around 15-20 per cent below the hourly rate paid by other retailers, even though pharmacists expected more from their staff. Proposed pay offers for 1996 averaged out at 2.25 per cent for managers; no rise for locums; 5 per cent for dispensers and 2.25 per cent for retail staff.

Mr Green believed business troubleshooter Sir John Harvey-Jones would have a field day if he looked at pharmacy: very few undertook work studies and ergonomics, and there had been very little modernisation.

also be looking into anything it regarded as suspicious. New rules meant automatic penalties for late or incomplete returns.

Pharmacists would be less likely to be assessed if their profits fell within the margins specified in the economic notes for dispensing chemists issued by the Revenue, according to Alan Smith, a pharmaceutical and legal consultant. These notes provided Revenue employees with a wealth of information about dispensing fees and reimbursement.

Although the notes were primarily intended as information for tax inspectors, they also provided a useful 'potted history' of NHS remuneration and profitability and highlighted contractors' dependence on attaining or exceeding the discount clawback if they were to maintain viability.

P medicines: the key to success

Pharmacists must capitalise on their monopoly of the Pharmacy medicines market in order to increase their profit margins, according to David Mitchell, commercial director of Johnson & Johnson MSD.

How pharmacists should adapt to be more profitable in the future was one of the main topics at the Institute of Pharmacy Management's meeting. Mr Mitchell demonstrated, using figures provided by IMS, how the value of the OTC medicine market had grown by \$189 million since 1993, but that pharmacy had lost 2 per cent of this to the grocery sector in that time.

In a market worth \$1.17 billion in 1995, this loss represented around \$29.2m, or \$3,500-4,000 per pharmacy. Pharmacists could not and should not compete with the buying and retailing expertise of the grocery chains, but should concentrate on P medicines, said Mr Mitchell.

It was possible that consumers who went to pharmacies, having seen POM to P products advertised, were put off by the questions pharmacists asked before selling the medicines. While Mr Mitchell believed that it was difficult in the current consumer environment for pharmacists not to ask these questions, he suggested that protocols did not have to be followed to the letter.

Mr Mitchell believed the slow growth of the P market and the loss of GSL business may be due to consumers being dissuaded by pharmacists' questions, which they felt were not appropriate,



J&J MSD's David Mitchell

and they simply went to a grocery store instead. There they could buy a GSL product, which they believed would do the same job, without the questions.

To illustrate the argument, he used the example of indigestion and heartburn remedies. The POM to P market, which consisted of three products, was worth only \$5m in 1995, despite multi-million pound advertising and marketing strategies by manufacturers. The GSL indigestion and heartburn market was worth \$58.7m in 1995 and, since 1993, pharmacy had lost 5 per cent of this to grocery.

POM to P switches had so far shown themselves to be safe and effective, but "the way pharmacists treat them you'd think they were a time bomb", said Mr Mitchell, who believed that pharmacies would capture a greater share of the market, because of the service and advice that well trained staff could provide.

How to survive in the future

Mike Rudin, superintendent pharmacist at Tesco, said that a pharmacy with a turnover of \$380,000 was looking at a net profit of around 2 per cent. Eight years ago, this would have been more like 8 per cent. However, if pharmacists could add 10 per cent to sales, this would double profits.

Mr Rudin asked two groups of participants to come up with

the six most important things pharmacists must do to survive in the future (see below). Mr Rudin believed that, as well as growing the medicines side, pharmacists should assess the profit they made per square foot from merchandise. They should identify their strengths and train staff in depth on these. Above all, he said, be customer-focused.

Two six-point plans for the survival of pharmacy

Group 1

- 1 Evaluate staff costs
- 2 Look at OTC product range
- 3 Look at depth of range
- 4 Be better communicators
- 5 Be more professional retailers, undertaking more promotional activity
- 6 Better time management

Group 2

- 1 Create a business plan
- 2 Look at areas you should be targeting and market strengths
- 3 Market your services to other healthcare professionals
- 4 Provide training for all staff
- 5 Make the pharmacist visible
- 6 Improve stock control

Zeneca denies continuing bid rumours

David Barnes, Zeneca's chief executive, fended off suggestions that Zeneca is a takeover target, after announcing a jump in operating profit of 12 per cent to \$894 million.

Zeneca revealed its 1996 results on the day the Ciba/Sandoz merger was announced and Zeneca shares rose sharply as a result of speculation that it is now one of the few companies suitable as a takeover target or with good merger potential.

Mr Barnes said that his primary aim was to "drive the business as hard and fast as we can" and give shareholders as good a deal as possible. The better the performance of the company, the more satisfied shareholders would be, and it was, he believed, an unfortunate paradox that the better looking the company and its product pipeline and the more vulnerable it was to takeover.

Mr Barnes added that the company was always alive to the possibility of acquisitions "given the inherent strength of organic growth in the business there is no imperative to do something just for the sake of doing something".

Company sales rose 9 per cent to \$4.9 billion and, although operating profits rose, after exceptional items, pre-tax profits fell 6 per cent to \$619m. Write-offs included \$197m on sales or closure of operations and \$65m restructuring costs.

The pharmaceutical division worldwide showed 10 per cent growth with sales of \$2,163m and like for like operating profit of \$687m (up 11 per cent).

In the UK, sales increased by 4 per cent. Zenest's share of the growing UK cardiovascular mar-



David Barnes, the chief executive of Zeneca

ket increased to just over 20 per cent and the launch of Zoladex LA was "very well received", according to Mr Barnes. However, overall UK growth was tempered by increased generic competition in Tenormin and Nolvadex.

Zestril buoyed overall sales of CV products, with growth of 12 per cent to \$547m. Tenormin and Inderal turned in flat performances, while other CV products dropped 50 per cent to give total sales of \$1,033m. The licence deal with Bayer for Sular will strengthen the company in this area, says Mr Barnes.

Cancer products brought in \$630m, helped by "a flying start" from Casodex, launched in October. Arimidex and Tamoxifen will continue to drive sector sales. In all major markets Zoladex sold well, as did Nolvadex, although strong generic competition in the US muted sales.

In CNS business, sales grew 18 per cent to \$336m and will be strengthened by Zeneca's recent acquisition of 311C from Glaxo Wellcome. Anti-infective products brought in \$152m.

Mr Barnes announced the sales of Zeneca's Speciality Inks business to Sun Chemical for \$62m and added that the company had also decided to sell its Textile Colour operation.

Rowland expands into South Wales

Pharmaceutical distributor and Numark agent L Rowland & Co (Wholesale) is expanding its business into South Wales with the opening of a wholesale depot in Cardiff.

Rowland, which already has a depot in Wrexham serving customers in North Wales, Cheshire and the Wirral, will be opening its new 10,000sq ft depot at Taffs Well on April 1. Alan Davies will be the new general manager, working alongside John Weekes, Rowland's sales representative for South Wales.

The expansion means up to 200 independent pharmacies in South Wales will be served by the depot, bringing the company's total customer base to over 450 independent pharmacies. Customers will benefit from a twice daily service, increased from once daily.

Rowland recently unveiled a \$650,000 capital investment programme at its Wrexham headquarters and became the UK's first independent pharmaceutical wholesaler to introduce a high-tech automatic picking system.

Unilever sells Rimmel-Chicago

Unilever is selling its cosmetics business, Rimmel-Chicago, to the German consumer group Benckiser for an undisclosed sum.

Rimmel-Chicago markets colour cosmetics in Europe, including the Rimmel and Sensiq brands. In addition, Benckiser will be granted a licence for Cutex brands in Europe. The company will also take over production facilities in Ashford, Kent, and Erkrath in Germany.

Rimmel-Chicago brands achieved sales of around \$75 million and they employ about 800 people, mainly in the UK, Germany and Italy. Benckiser's cosmetics business, Coty, turned in sales of \$950m in 1995.

Unilever is current undergoing

a major restructuring programme and the sale is part of a move away from cosmetics to concentrate on prestige and mass market toiletries. The company also wants to focus on products with global potential, which, it says, Rimmel-Chicago goods do not have.

Meanwhile, Benckiser, which recently failed in its bid to buy the US cosmetics business Maybelline, says the acquisition will strengthen its number two position in the European colour cosmetics market and will give it the chance to capitalise on synergies with its existing business in areas including R&D.

Benckiser expects the acquisition to be complete by the end of April.

Swiss merger creates new giant

Swiss pharmaceutical companies Ciba and Sandoz are merging to create Novartis - the second-largest pharmaceutical company in the world.

News of the \$50 billion deal sent shares in drug companies soaring as speculation increased regarding the next participants in 'mergermania'. Zeneca, Bayer and Warner-Lambert are among the companies yet to participate in industry restructuring.

Ciba shareholders will receive 45 per cent of the shares in the new company, with the rest going to Sandoz: the deal is a merger rather than a takeover, so that in future Novartis will not be hampered by debt. The company estimates that it will make savings of \$1bn over the next three years.

However, up to 600 jobs could go in the UK as the company rationalises the merged businesses. Around 1,500 people work for Sandoz and almost 5,000 for Ciba in the UK. Although neither company has given specific details of cuts, Novartis aims to trim its workforce by 10 per cent worldwide.

The merger will catapult Novartis' drug business to second place in the global drug industry, with a market share of 4.4 per cent and sales of around \$7.5bn (including prescription drugs, over the counter and vision products).

Novartis will rank seventh in

the self-medication market, with consolidated sales in 1995 at \$800 million. The company predicts that future growth will be driven by POM to P switches, key product extensions and geographic expansion.

The new company will focus on OTC brands for treating pain, cough, cold, allergy, GI problems, smoking cessation and skin disorders. Key brands include Ex-Lax, Maalox and Otrivine.

The merger gives the new company good geographic coverage for launching future products and maximising OTC switches, such as Nicotinell (for smoking cessation) and Lamisil cream (for fungal infections).

In pharmaceuticals, Novartis will focus on seven therapeutic areas: immunology/inflammatory disease; CNS disorders; cardiovascular; endocrine and metabolic disorders; oncology; dermatology; and asthma. The company's leading products will be Voltaren, Ciba's pain reliever for arthritis; and Sandimmun, Sandoz's anti-rejection drug.

There are over 94 major products in the company's pipeline, including Letrozole for breast cancer, Exelon for Alzheimer's and Valsartan for hypertension.

Dr Alex Krauer, chairman of Ciba, will be chairman of the new company, and Dr Daniel Vasella, chief executive of Sandoz, will become Novartis' president.

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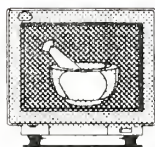
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ABOUT people

Farewell, Lord Peston

Lord Peston attended his last Royal Pharmaceutical Society Council meeting last week as a Privy Council member.

He joined Council in 1986 and was a member of the Nuffield inquiry. At last week's meeting, RPSGB president Ann Lewis thanked him for his enormous contribution to pharmacy. He would be greatly missed, she said.

Lord Peston retired in 1994 from his post of professor of economics, Queen Mary College, University of London. During his career he acted as economic adviser to several Government departments.

The Privy Council will appoint a successor, but none had been notified to the Society at the time of going to press.



A state of the art IBM computer will be taking pride of place at Mohinder Bhari's home, thanks to Roche Consumer Health's Aspro Clear prize draw. Mr Bhari (left) is pictured in his Hounslow outlet, Beaver Pharmacy, with Aspro Clear product manager Nigel Conquest and Roche territory manager Jim Verden



Making an impression

Wiltshire Local Pharmaceutical Committee secretary Ray Jephson found himself sitting next to Andrew Hudson, head of health expenditure at the Treasury, at last week's Pharmaceutical Services Negotiating Committee dinner in London. It was Mr Hudson's first day in the post.

With health secretary Stephen Dorrell's recommendation that the best way to learn about phar-

macy is to visit one, Mr Hudson could hardly refuse Mr Jephson's invitation to visit his business in Wroughton, near Swindon. An early April date has been fixed.

Mrs S Danji of Charles Sampson Pharmacy, London N12, also took up Mr Dorrell's suggestion and has invited her MP, Sir Sidney Chapman, to sample what pharmacy has to offer, such as advice on smoking cessation.

"Our window display for No Smoking Day might not be the winning entry, but it does show involvement," she says.

The No Smoking Day window at the Charles Sampson Pharmacy, London N12

Pharmacy's charity week for local day care centre

Wanstead Pharmacy in east London is to donate 10 per cent of this week's takings on non-medicine products to the local day care centre.

Pharmacist manager Ali Mashadi comments that he expects to raise £300-400 for the centre. Wanstead Day Centre provides 500 meals a week for elderly people and needs a new freezer. Mr Mashadi hopes he will raise enough money to buy one, although he will leave it to the centre to decide what to buy with the money.

Takings were 15 per cent higher than usual on Monday. "A lot of people came in to congratulate us and wish us well," says Mr Mashadi.

The charity week is just one of the ventures lined up to improve the pharmacy's services to residents. On June 1, the outlet will introduce a *bureau de change* and travel insurance facilities to its already established post office section.

"For some reason we have a lot of Argentinian and Spanish people staying locally," explains Mr Mashadi.

A new Boots' branch opens on the same High Street this week, after two other pharmacies closed, but Mr Mashadi says the charity event was planned long ago and is not as a result of the opening. He was quoted in the local newspaper as saying he was looking forward to a complementary relationship rather than a competitive one with the Boots' store, and was confident his customers would stay with him.

COMING EVENTS

SUNDAY, MARCH 17

Slough Branch, RPSGB

At the Postgraduate Medical Centre, Edgware General Hospital, Barnet, 10.00am to 4.00pm. 'Patients and medicines - expectation and reality'.

Harrow & Hillingdon Branch, RPSGB

At the Northwick Park Hospital, 7.30 for 8.10pm. Chiltern Regional Conference. 'Taxation and how it affects the employed, self-employed and small businesses' by Brian Murgatroyd, former tax inspector.

TUESDAY, MARCH 19

Leicestershire Branch, RPSGB

At the Post Graduate Medical Centre, Leicester Royal Infirmary, 7.30 for 8.00pm. Post Grad 3: 'Do Welsh pharmacists do it better?' by Dr Dai John and Stuart Evans.

Scottish Department, RPSGB

At the Society's House, 36 York Place, Edinburgh, 7.45pm. 'Is there life after stress?' with Professor Shirley Fisher, Centre for Occupational Health &

Psychology, University of Strathclyde, Glasgow.

East Metropolitan Branch, RPSGB

At Wanstead Library, Spratt Hall Road, London E11, 7.30 for 8.00pm. 'Diabetes and obesity' by Dr Peter Kopelman, consultant at the Royal London Hospital.

THURSDAY, MARCH 21

Bedfordshire Branch, RPSGB

At the Cedar Room of the Conference Centre, Silsoe College, 8.00pm. 'Council member's viewpoint' with Hemant Patel.

Advance information

The Young Pharmacists' Group

is holding its Pennine Regional Conference 'Pharmacy in a New Age' on **March 24**, at the Novotel, Worsley, Manchester: Details, tel: 0161 747 5015.

British Pharmaceutical Students Association

is holding its 54th Annual Conference in Leicester, **April 7-14**. Details, tel: 01203 602020 ext 8500.

CPP board nominations

Five members of the College of Pharmacy Practice have been nominated to stand for election on to the College's board of governors.

They are:

- Claire Anderson, lecturer in community pharmacy at King's College, London, and local tutor for the Centre for Pharmacy Postgraduate Education

- Charles Butler, managing director and superintendent pharmacist for J R Butler Chemists

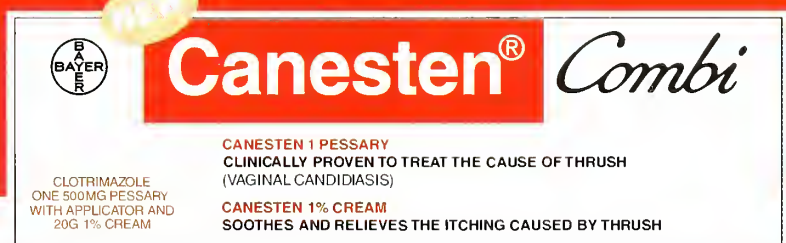
- Graham Conkie, principal pharmacist at Glasgow Western Infirmary

- Alan Crabbe, proprietor pharmacist in Rhydyfelin, Pontypridd in Wales

- David Morgan, director of pharmaceutical public health for Clwyd and Gwynedd, and the local immunisation co-ordinator.

There are four vacancies on the College's board of governors and the results will be announced at the College Day on April 25.

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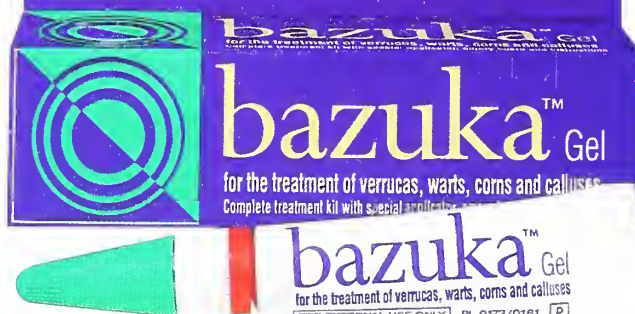
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